

**Cardiac Testing:** Medical Centre 1: Suite 206, 430 The Boardwalk, Waterloo, ON, N2T 0C1

**Pulmonary Testing:** Medical Centre 2: Suite 303, 435 The Boardwalk, Waterloo, ON, N2T 0C2

Phone: 519-741-5252 Fax: 519-741-5772 email: [cps.booking@kwcps.com](mailto:cps.booking@kwcps.com)

## REQUEST FOR TESTING

**Urgency:**  Elective  Urgent

**Indication:** *(Requisitions with insufficient information will be returned)*

- Chest pain  Palpitations  Syncope  Murmur  Hypertension  
 Dyspnea  Cough  COPD  Asthma

CLINICAL INFORMATION:

### CARDIAC TESTING

- Echocardiogram
- Echo with add on  Contrast or  Bubble Study
- Electrocardiogram (ECG)
- Holter Duration  24 hr  48 hr  72 hr  
 7 day  14 day
- Ambulatory Blood Pressure Monitor  
*(\$75 fee, not covered by OHIP)*
- Exercise Stress Test\*
- Exercise Stress Echocardiogram\*
- Dobutamine Stress Echocardiogram\*  
*(\*Consults will be conducted at cardiologists discretion, for all stress testing please include CPP and recent blood work)*

### PULMONARY TESTING

- Full Pulmonary Function with Bronchodilator
- Full Pulmonary Function without Bronchodilator
- Spirometry with Bronchodilator
- Spirometry without Bronchodilator
- Arterial Blood Gases  On Room Air  On Oxygen
- Neuromuscular Protocol  
 (Full Pulmonary Function with MIPs & MEPs and Seated & Supine Spirometry)

**PATIENT INFORMATION**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_  
 DOB:(mm/dd/yyyy) \_\_\_\_\_ VC: \_\_\_\_\_  
 Health Card Number: \_\_\_\_\_  
 Phone: \_\_\_\_\_  
 Email: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Street \_\_\_\_\_  
 City \_\_\_\_\_ Province \_\_\_\_\_ PC \_\_\_\_\_  
 Gender:  Female  Male  \_\_\_\_\_  
 Patient Height \_\_\_\_\_ Weight \_\_\_\_\_  
 Patient requires translator: *Language* \_\_\_\_\_

**REFERRING PHYSICIAN**

Name: \_\_\_\_\_ Billing#: \_\_\_\_\_  
 Phone: \_\_\_\_\_  
 Fax: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Street \_\_\_\_\_  
 City \_\_\_\_\_ Province \_\_\_\_\_ PC \_\_\_\_\_  
 Additional copies: \_\_\_\_\_  
 Referring Physician's Signature: \_\_\_\_\_  
 Has this patient been seen by a CPS Physician?  
*if yes Specify:* Dr. \_\_\_\_\_

*if requesting a consultation: See CPS Request for Consultation requisition.*