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

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
($60 fee, not covered by OHIP)

❍Exercise Stress Test*

❍Exercise Stress Echocardiogram*

❍Dobutamine Stress Echocardiogram*

*(*Consults will be conducted at cardiologists discretion)*

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)

❍FeNO (Exhaled Nitric Oxide Level)
($85 fee, not covered by OHIP)

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

PATIENT INFORMATION

Last Name: First Name:

DOB:(mm/dd/yyyy)
Health Card Number: VC:

Phone:

Email:

Address:

Street

City *Province* *PC*

Gender: ❍Female ❍Male ❍_____

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. _____

Online at kwcps.com and oceanhealthmap.ca