SUMMIT CARDIOLOGY

Dr. Omid Kiamanesh, MD, FRCPC
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FAX TO **587 330 3002**

PATIENT		**REFERRING PHYSICIAN**	
NAME		NAME	
PHN / ULI		PRACID	
PHONE		PHONE	
DOB		FAX	

REFERRAL

CONSULT REQUEST	☐ URGENT	☐ ROUTINE
☐ RISK STRATIFICATION	☐ DYSPNEA	☐ VALVE
☐ CHEST PAIN	☐ ARRHYTHMIA	☐ OTHER:

TEST REQUEST

☐ ECHOCARDIOGRAM	☐ TREADMILL TEST	☐ CAROTID ULTRASOUND
☐ STRESS ECHOCARDIOGRAM	☐ HOLTER MONITOR	☐ OTHER:

RELEVANT INFORMATION

We will confirm receipt and book directly with your patient. Thank you for your referral.

Tel 587 330 3001
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