SportsCardiologyBC
Referral Form

1. Demographics

Patient: _____ DoB: _____/____/_____

PHN: _____ Sex: ❑M ❑F

1° Ph #: (_____) _____- _____ 2° Ph #: (___) _____- _____

email: _____

MD: _____

MSP_____

Ph #: (___) _____- _____

Fx #: (___) _____- _____

Height: _____cm. Weight: _____kg. Waist: ____ cm.

Sport: _____ Level: ❑Professional ❑National ❑Varsity ❑High School ❑Recreational

2. Current Medications (drug, dose, frequency)

_____

_____

Allergies

❑NKA

❑Allergy:_____

3. Past Medical History

❑ Hypertension ❑ Dyslipidemia ❑ Smoking ❑ Diabetes ❑ Family History of Premature CAD

❑ Other: _____

4. Reason for Cardiovascular Evaluation

_____

_____

_____

5. Test Results (please attach if available)

❑ ECG ❑ Holter ❑ ETT ❑ Blood Work ❑ ECHO ❑ CMRI ❑ CT ❑ CACS ❑ MIBI

❑ CATH ❑ PET