**C-era (a division of C-health)**
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# C-ERA CARDIOMETABOLIC EVALUATION & RISK ASSESSMENT REFERRAL FORM

**PATIENT INFORMATION** (attach patient label)

Patient Name: ☐M ☐F
ULI: DOB:
Address: Postal Code:
City, Province: Home phone:
Email:

**REFERRING PHYSICIAN INFORMATION**

Physician Name: _____
Practice ID: _____
Clinic Name: _____
Clinic Address: _____
Ph: _____ Fax: _____

Date of Referral: _____

REASON FOR REFERRAL

**Cardiometabolic Assessment**

☐ Risk Assessment ☐ Syncope
☐ Chest Pain ☐ Abnormal ECG
☐ Shortness of Breath ☐ Atrial Fibrillation

☐ Other: _____

**Direct to Treadmill (DTT) via C-diagnostics**

☐ Please consider this patient for DTT*
*** MUST *include recent ECG***
*See C-diagnostics requisition for additional tests available*

**Direct to MIBI/Nuclear (DTN) via C-diagnostics**

☐ Please consider this patient for DTN*
*** MUST *include recent ECG***
*See C-diagnostics requisition for additional tests available*

**Consultation Request**

☐ Cardiology
☐ Internal Medicine

**Please include all relevant diagnostic testing:**

☐ ECG
☐ Labs (Lipid Panel, GLUF)
☐ Previous Cardiac Investigations

Relevant History:

☐ **URGENT** ☐ First Available ☐ Routine

Referring Physician Signature:

_____

C-era is now offering **general cardiology** consultations along with our cardiometabolic risk evaluation services.

**BOOKING WITHIN 1 WEEK**

***C-era - A centre of excellence committed to specialty-based cardiometabolic care***