Bushidi's HEART CLINIC

Unit P1-C2, 800 Rosser Avenue
Brandon, MB R7A 6N5
TEL 204.717.7800
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bushidiheart.com
contact@bushidiheart.com

REFERRAL FORM

Please fax to 1-204-717-7801

Patient Name: _____ **Referring Physician**: _____
PHIN/MHSC: _____ **Family Physician**: _____
DOB: _____ **Gender**: _____ **Patient Contact Number**: _____
Patient Address: _____
E-Mail: _____

LEVEL OF URGENCY:

☐ Emergent (Page Dr. Bushidi at 204-578-4000 or send to ER)
☐ Urgent (Provide convincing medical reasons, if in doubt page Dr. Bushidi 204-578-4000 or send to ER)
☐ Semi Urgent
☐ Elective

REASON OF REFERRAL: *(Please fill in all applicable boxes below)*

☐Chest Pain ☐ Heart Failure ☐ Arrhythmia ☐ Syncope ☐ EKG (Only) ☐24 Hour Blood Pressure (Only)
☐ Valvular Disease ☐ Pulmonary Hypertension ☐Pre-operative Assessment ☐ Undiagnosed SOB
☐ Coronary Artery Disease ☐ Other _____

CLINICAL INFORMATION/INDICATIONS:

INVESTIGATION ALREADY AVAIABLE:
(Please attach reports if available)

	Date	Location
☐ EKG		_____
☐ ECHO		_____
☐ Holter Monitor		_____
☐ MIBI		_____
☐ Stress EKG		_____
☐ Coronary Angiogram		_____
☐ CXR		_____
☐ Lung Function Test		_____
☐ Recent Blood Test		_____

Referring Physician Signature: _____ Date: _____

PLEASE NOTE THAT WE ASSUME THAT PATIENTS REFERRED TO DR. BUSHIDI AS OUTPATIENT ARE STABLE AND CAN WAIT FOR AN OUTPATIENT CONSULTATION, KEEPING MIND THAT THE WAIT TIME CAN BE 6-12 MONTHS. IF IN DOUBT, PLEASE CONTACT DR BUSHIDI AT 204-578-4000 TO MOTIVATE FOR URGENT CONSULTATION OR TO DISCUSS ALTERNATIVE OPTIONS SUCH AS HOSPITAL ADMISSION.