REFERRAL FORM

144-6th Street
Brandon, MB R7A 3N2
TEL 204.717.7800
FAX 204.717.7801
bushidiheart.com
contact@bushidiheart.com

Please fax the completed form with enclosures to 1-204-717-7801.

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

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 ☐ Undiagnosed SOB
☐Coronary Artery Disease ☐ Valvular Disease ☐ Pulmonary Hypertension ☐Pre-operative Assessment
☐ Other _____

IN CLINIC TESTING AVAILABLE BY REFERRAL:

☐ 24 Ambulatory Blood Pressure Monitoring ☐ EKG Only ☐ Ankle-Brachial Index

CLINICAL INFORMATION/INDICATIONS

INVESTIGATIONS ALREADY AVAIABLE:
(Please attach reports if available)

☐ EKG

☐ECHO

☐ Holter Monitor

☐ MIBI

☐ Stress EKG

☐ Coronary Angiogram

☐ CXR

☐ Lung Function 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.