

\*\*\* NOTE: Incomplete and / or unsigned requisitions will be returned! OR AFFIX LABEL WITH COMPLETE INFORMATION

MARKHAM STOUFFVILLE HOSPITAL CORPORATION

**CHEST PAIN CLINIC  
REFERRAL**

Markham Site Booking Line: (905) 472-7601 Fax: (905) 472-7621

Appointment Date & Time: \_\_\_\_\_

Hospital MRN #: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex: **F** **M**

Health Card # \_\_\_\_\_ Version Code: \_\_\_\_\_

Telephone # Home: \_\_\_\_\_

Other Telephone #: \_\_\_\_\_

|       |              |           |            |
|-------|--------------|-----------|------------|
| Date: | Referring MD | Signature | MD Phone # |
|-------|--------------|-----------|------------|

Additional Reports to:

|                                       |  |         |
|---------------------------------------|--|---------|
| Spoken Language if other than English | Contact Information for Translator if Required Name: | Phone # |
|---------------------------------------|--|---------|

**CHEST PAIN CLINIC REFERRAL POST ACS FOLLOWING:**

ANGIOGRAM

PCI

Please fax referral and Angiogram/PCI report to :

Fax: (905) 472-7621

Phone: (905) 472-7601

Our clinic will contact the Patient directly for an appointment within 72 hours.

Patient's daytime phone number is \_\_\_\_\_

Clinical concerns/comments:

---



---



---



---



---



---



---



---



---



---

