Provincially Accredited Echo Lab and Member of the Cardiac Care Network

COLLINGWOOD CARDIOLOGY
& INTERNAL MEDICINE

# Consultation/Follow up

Patient Label:

Reason for Consultation: ______________________________________________

______________________________________________________________

______________________________________________________________

______________________________________________________________

Please provide relevant information: ______________________________________

History: *(Include or attach a list of current medications, allergies, and any cardiac test results.)*

______________________________________________________________

______________________________________________________________

______________________________________________________________

______________________________________________________________

Allergies: ____________________________________________________

______________________________________________________________

Signature: ________________________ Date: ____________________

1 Huron Street, Suite 201, Collingwood, ON L9Y 1C3
Tel: 705-444-1648 Fax: 705-444-1909 Email: cc@collingwoodcardiology.com