Tel: **705-327-9115** Fax: **705-325-3985**

REQUEST FOR

Cardio-Diagnostics

• BY APPOINTMENT ONLY •

PATIENT INFORMATION	MRN Nº.	APPOINTMENT DATE:	TIME:
☐ IN-PATIENT ☐ OUT-PATIENT ☐ ER			ARRIVAL TIME:

Last Name		First Name	☐ M ☐ F
Date of Birth (D/M/Y)	Health Card Nº.	WSIB Nº.	3rd Party Ins. Nº.
Address		City	Postal Code
Email Address		Contact Number	☐ OK to leave voice mail message

Patient is able to give consent for this procedure: ☐ Yes ☐ No | Does the patient have a glucose monitoring device? ☐ Yes ☐ No

If patient unable to give consent, please ensure SDM attends with the patient and has appropriate documentation.

☐ SDM Name: ☐ SDM Contact Information:

☐ Patient requires assistance to complete this imaging exam, *e.g. mobility, translation* Please Specify:

REQUIRED TESTS:

☐ 12-LEAD ECG

HOLTER MONITOR

☐ 24 HR

☐ 48 HR

☐ 72 HR

☐ 7 DAY

☐ 14 DAY

☐ **ACUTE CARDIAC EVALUATION SERVICES**
(For urgent assessment only. This includes a consultation with internal medicine. ***Please check testing required.****)*

INDICATION FOR URGENT ASSESSMENT:

☐ AMBULATORY BLOOD PRESSURE MONITOR ***(uninsured, patient fee $75)***

☐ CARDIAC STRESS TEST ***(if the patient has no previous CAD, please hold rate reducing medication, if possible)***

NUCLEAR PERFUSION STUDIES ***(Referral must be made by internal medicine or cardiologist. No caffeine or dairy 24 hours prior to testing.)***

☐ Exercise Cardiolite Stress Test

☐ Persantine Cardiolite Stress Test

REQUESTS FOR TESTING SHOULD INCLUDE ER REPORT OR PATIENT PROFILE, MEDICATION LIST AND ANY PRIOR CARDIAC DIAGNOSTIC STUDIES (ECG, ECHO, BLOOD WORK, INTERVENTIONAL PROCEDURES).

CLINICAL INFORMATION	MEDICATION

Physician's Name (Please PRINT clearly)		Physician's Signature
Phone	**CPSO#**	

INCOMPLETE, ILLEGIBLE AND/OR UNSIGNED REQUISITIONS WILL BE RETURNED.

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