

REQUEST FOR

Cardio-Diagnostics

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

IN-PATIENT       OUT-PATIENT       ER       ARRIVAL TIME:         Last Name       First Name       Name       M         Date of Birth (D/M/Y)       Health Card N <sup>0</sup> .       WSIB N <sup>0</sup> .       3rd Party Ins. N <sup>0</sup> .         Address       City       Postal Code         Email Address       Contact Number       OK to leave voice mail messa         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, <i>e.g. mobility, translation</i> Please Specify:         REQUIRED TESTS:       ACUTE CARDIAC EVALUATION SERVICES         (21 LEAD ECC       Cortuge to accord accord and the induction on the induction of the induction on the induction of	PATIENT INFORMATION MRN			APPOINTMENT DATE:			TIME:			
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Please check testing required.)	12-LEAD ECG	(For urgent assessment only. This includes a consultation with internal medicine.								

HOLTER MONITOR

## 24 HR

🗌 48 HR

272 HR

🗌 7 DAY

14 DAY

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*)

INDICATION FOR URGENT ASSESSMENT:

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).

MEDICATION

Physician's Name (Please PRINT clearly)		
Phone	CPSO#	
INCOMPLET Document #: 3814	Physician's Signature	
v.2		