|  |  |  |
| --- | --- | --- |
| E:\Essential New Logo\Logo version 2\logo_files\SmallLogo.jpg | **Essential Cardio Diagnostics****Holter Test Requisition Form** | **Tel: 647-878-5766****Fax: 647-930-1688****luyao@ecdcorp.ca****www.ecdcorp.ca** |

**INDICATION:**

[ ]  Dizziness

[ ]  Light headedness

[ ]  Palpitations

[ ]  Abnormal ECG

[ ]  Syncope

[ ]  Pre-syncope

[ ]  Prosthetic Valve

[ ]  Emphysema/COPD

[ ]  Arrhythmia

[ ]  Rhythm Assessment

[ ]  Fatigue

[ ]  Weakness

[ ]  Leg Swelling

[ ]  Post MI/CABG/PTCA

[ ]  CHF

[ ]  Stroke

[ ]  Heart murmur

[ ]  Heart defect

[ ]  Chest Pain/Discomfort

[ ]  Shortness of Breath

[ ]  Smoker

[ ]  Overweight/Obese

[ ]  Hypertension

[ ]  LVH

[ ]  Diabetes

[ ]  Ischemic Heart Disease

[ ]  Dyslipidemia

[ ]  Family History of: \_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  Pace-maker user

 Pacing mode: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  **Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PATIENT INFORMATION**

Last Name:

First Name:

Date of Birth:

Sex:

OHIP Number:

Address:

Telephone:

**CARDIAC TEST:**

**Holter Monitoring Time:** [ ]  48 Hours [ ]  72 Hours [ ]  14 days

**CARDIAC CONSULTATION:**

[ ]  Dr. Raymond Yan [ ]  Dr. Derek Yung [ ]  Dr. Bhavanesh Makanjee

**Other Relevant Clinical Information/Medications:**

**Holter Hook-up Information:**

Technician Name:

**Monitor Hook-up Appointment:**

Date:

Monitor Start Time:

**REFERRING DOCTOR:**

Name:

Billing Number:

CPSO Number:

Clinic Address:

Telephone:

Fax Number:

Signature: Date: