



Essential Cardio Diagnostics Holter Test Requisition Form

Tel: 647-878-5766
Fax: 647-930-1688
luyao@ecdcorp.ca
www.ecdcorp.ca

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:

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: _____

REFERRING DOCTOR:

Name:

Billing Number:

CPSO Number:

Clinic Address:

Telephone:

Fax Number:

Signature:

Date:

Holter Hook-up Information:

Technician Name:

Monitor Hook-up Appointment:

Date:

Monitor Start Time:

Please fax this request form to 647-930-1688