



Patient Last Name		First Name		Date of Birth		<input type="checkbox"/> M	<input type="checkbox"/> F
Address		Town/City		Postal Code			
OHIP No.		Telephone		<input type="checkbox"/> Verbal Report <input type="checkbox"/> STAT			
Clinical Information		LABEL					
Referring Physician							
Signature	Billing #						
C.C. Dr.	Fax						

CONSULTATION AND APPROPRIATE TESTING

- | | |
|--|--|
| <input type="checkbox"/> Consultation | <input type="checkbox"/> Ambulatory Blood Pressure Monitor (\$50) |
| <input type="checkbox"/> Consultation (if test result is abnormal) | <input type="checkbox"/> 12 Lead ECG |
| <input type="checkbox"/> 2D Echocardiogram | <input type="checkbox"/> Digital Holter Monitoring <input type="checkbox"/> 48 Hours <input type="checkbox"/> 72 Hours |
| <input type="checkbox"/> Stress Test | <input type="checkbox"/> Continuous ECG / LOOP Cardiac Monitoring (14 days) |
| <input type="checkbox"/> Stress Echocardiography | |
| <input type="checkbox"/> NUCLEAR CARDIOLOGY | |
| <input type="checkbox"/> MYOCARDIAL PERFUSION (CARDIOLITE/SESTAMIBI) <input type="checkbox"/> Exercise <input type="checkbox"/> Persantine | |

PHYSICIAN'S NOTE: PLEASE INFORM THE PATIENT REGARDING THE DISCONTINUATION OF BETA BLOCKERS, CALCIUM BLOCKERS, AND ERECTILE DYSFUNCTION MEDICATIONS 48 HOURS PRIOR TO TEST

INDICATIONS FOR CARDIOLOGY TESTING

- | | | |
|---|--|---------------------------------------|
| <input type="checkbox"/> Chest Pain or Discomfort / Angina | <input type="checkbox"/> Pulmonary HTN | <input type="checkbox"/> Abnormal ECG |
| <input type="checkbox"/> Shortness of Breath / Fatigue | <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Abnormal CXR |
| <input type="checkbox"/> Murmur / Valvular Heart Disease / Extra Heart Sounds | <input type="checkbox"/> Ejection Fraction / LV Function | <input type="checkbox"/> Other |
| <input type="checkbox"/> Palpitations / Arrhythmia / Bradycardia | <input type="checkbox"/> Wheezing | |
| <input type="checkbox"/> Dizziness / Syncope / Presyncope | <input type="checkbox"/> Crepitus | |
| <input type="checkbox"/> Stroke / TIA | <input type="checkbox"/> Edema | |
| <input type="checkbox"/> Peripheral Vascular Disease | <input type="checkbox"/> Pace Maker / AICD | |
| <input type="checkbox"/> Congenital Heart Disease | | |

MODERATE TO HIGH RISK

- | | | |
|--|--|---|
| <input type="checkbox"/> Age | <input type="checkbox"/> Hypertension | <input type="checkbox"/> High Stress |
| <input type="checkbox"/> Family History | <input type="checkbox"/> Smoking History | <input type="checkbox"/> Dyslipidemia |
| <input type="checkbox"/> Ethnicity | <input type="checkbox"/> Obesity | <input type="checkbox"/> Poor Diet |
| <input type="checkbox"/> Diabetes Mellitus | <input type="checkbox"/> Sedentary Lifestyle | <input type="checkbox"/> Metabolic Syndrome |

* Please bring with you this requisition form, your health card and your list of medications. Thank you for your cooperation.

FOR PATIENT INSTRUCTIONS VISIT OUR WEBSITE: www.pdxn.ca