Home Holter Requisition

(RESPONSE TO COVID-19)

Online Requisitions: www.cardiostudy.ca/holterreq

Fax: 1-800-728-7019

Cardio Study

Name: _____ (M / F) ☐☐
(Last Name) (First Name)

Test Request Date: _____

Date of Birth: _____
Day / Month / Year

Adult (≥ 18): ☐ Pediatric (≤ 17): ☐

H.C.#: _____ V.C.: _____

Physician Billing Number: _____

Referring Physician: _____

Signature: _____
(Referring Physician)

Place label / sticker here
(or print info above)

Check off the test requested:

☐ 3 day recording

☐ 14 day recording

☐ Other_____

Indications

- ☐ Abnormal ECG
- ☐ Palpitations
- ☐ Syncope / Fainting Spells
- ☐ Presyncope / Light-headedness
- ☐ Chest Pain / Shortness of Breath
- ☐ Fatigue / Weakness
- ☐ R/O Atrial Fibrillation / Flutter
- ☐ Atrial Fibrillation Rate Control
- ☐ Post Stroke / TIA
- ☐ Atrial Arrhythmia
- ☐ Medication Effect
- ☐ Ventricular Arrhythmia
- ☐ PACEMAKER ☐ VVI ☐ DDD
- ☐ Other: _____

In office consultation / Telemedicine

☐ **CARDIOLOGY CONSULT**

We offer in office consultation as well as **virtual in home** consultation via telemedicine, and we will schedule the appropriate venue with the patient.

Comments:_____

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