Holter Requisition

Cardio Study

Suite 201 - 343 Wilson Ave, Toronto, ON, M3H 1T1
Tel: 1-800-796-3035 Fax: 1-800-796-3037

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

Date of Birth: _____
Day / Month / Year

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

Referring Physician: _____

Test Start Date: _____

Adult (≥ 18): ☐ Peadiatric (≤ 17): ☐

Technician: _____

Signature: _____
(Referring / Supervising 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: _____

Patient Instructions

Your physician has ordered a Holter Monitor for you so that we can record your heart's electrical activity while you go about your daily routine. To improve the usefulness of the test, we would like you to record any symptoms that you experience accurately in this diary (date and time of the following symptoms) including:

1. Strenuous or unusual physical or emotional activity
2. Symptoms such as chest discomfort, dizziness, palpitations, shortness of breath, fainting, etc.

Please record in your diary the exact time of day that these symptoms occur and include the circumstances or activity associated with those symptoms.

Please do not shower, bath or swim with the recorder on. The diary must be returned with the recorder.

Patient Name: ____________________________

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PATIENT DIARY

Patient Cellphone #: ________________

Patient Health Card number: ______________________

Please record all the *MEDICATIONS* including the dosage and how often they are taken.

1. ______________________________________
2. ______________________________________
3. ______________________________________
4. ______________________________________
5. ______________________________________
6. ______________________________________
7. ______________________________________
8. ______________________________________

DATE	TIME	SYMPTOM	ACTIVITY