Cardio Study

Holter Requisition

LX Remote Online Transfer | British Columbia
Tel: 1-800-796-3035 Fax: 1-800-331-7784

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

Date of Birth: _____
Day / Month / Year

PHN: _____ V.C.: _____

Referring Physician: _____

Repeat Test in: _____ months

Test Start Date: _____

Adult (≥ 18): ☐ Peadiatric (≤ 17): ☐

Technician: _____

Signature: _____
(Referring Physician)

Place label / sticker here
(or print info above)

Check off the test requested:

☐ 24 Hours

☐ Other_____

Indication

- ☐ Abnormal ECG
- ☐ Palpitations
- ☐ Syncope / Fainting Spells
- ☐ Presyncope / Light-headedness
- ☐ Chest Pain / Shortness of Breath
- ☐ Fatigue / Weakness
- ☐ R/O Atrial Fibrillation / Flutter
- ☐ A-fib 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).

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

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