REQUEST FOR CARDIOVASCULAR SERVICES TESTING

□ Non-Urgent □ Urgent

Date (YYYY/MM/DD): _____/____/____

Patient's Full Name: _____

Patient's Phone #:_____Patient's DOB (YYYY/MM/DD): _____/____/____

Clinical Indication:

_____

_____

_____

No Appointment Required:

☐ ELECTROCARDIOGRAM (EKG) ☐WITH RHYTHM STRIP

By Appointment Only: **PLEASE CALL 613-345-5649 EXT. 51156 OR FAX 613-345-8330**

☐ AMBULATORY MONITORING (HOLTER): ☐ 24 HR ☐48 HR ☐ 72 HR

☐ LONG TERM HOLTER MONITOR: ☐ 7 DAY

☐ 14 DAY (Patient **must** return on Day **7**)

Indications for 7/14 day holters: Stroke/TIA investigations, AF/PAF, SVT, Pauses, Risk of sudden cardiac death, infrequent symptoms, Syncope and pre-syncopal episodes. Final Report is Qualitative.

Ordering Physician: _____

Physician's Signature: _____

Copy To: _____