2475 McDougall Avenue, Suite 110, Windsor, ON N8X 3N9
TEL: (519) 987-0611 24-HOUR FAX: (519) 987-0583

REQUISITION FORM

PATIENT INFORMATION: **DATE:** _____

Patient Name: _____ DOB: (D/M/Y) _____/_____/_____

Address: _____

City: _____ Province: _____ Postal Code: _____

Home Phone: _____ Other Phone: _____

OHIP #: __ __ __ __ - __ __ __ - __ __ __ Version Code: _____

REQUEST: (Choose one or more of the following)

- ☐ Cardiac Assessment/Consultation **Only**
- ☐ Exercise Stress Test **Only**
- ☐ Exercise Stress Test **with** Consultation
- ☐ Loop Recorder
- ☐ 24-hr Holter Monitor ☐ 48-hr Holter Monitor
- ☐ 12-Lead EKG
- ☐ Ambulatory BP Monitor (Non-OHIP)
- ☐ Echocardiogram

REASON FOR REFERRAL:

- ☐ Syncope
- ☐ Palpitations
- ☐ Dyspnea
- ☐ Dizziness
- ☐ Dyslipidemia
- ☐ Shortness of Breath
- ☐ Diaphoresis
- ☐ Nausea
- ☐ Chest pain or discomfort
- ☐ Cardiovascular Assessment/Prevention
- ☐ Hypertension
- ☐ TIA/Stroke
- ☐ Diabetes

☐ Other _____

REFERRING PHYSICIAN:

Name: _____ Signature: _____

CC: _____

Provider #: _____ Telephone: _____ Fax: _____

⇨ **PATIENT MUST BRING IN THEIR CURRENT HEALTHCARD AND CURRENT LIST OF MEDICATIONS**

APPOINTMENT DATE & TIME: _____