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REQUISITION

CARDIOLOGY		EEG (ELECTROENCEPHALOGRAM) (5 years and older)
Holter Monitor (with ECG) ☐ 48 Hrs ☐ 7 Days ☐ 72 Hrs ☐ 14 Days	☐ Echocardiogram (ECHO) ☐ Electrocardiogram (ECG ONLY) ☐ Cardiac Stress Test (TMT)	☐ Routine with video recording ☐ Sleep deprived (SD)

PATIENT INFORMATION	
Name:	D.O.B: Gender: ☐ M ☐ F
Address:	Cell: Alt:
City: Prov: Postal code:	Health Card #:

REASON FOR REFERRAL			
☐ Dizziness	☐ Chest Pain	☐ Seizures	☐ Other:
☐ Palpitations	☐ Short of Breath (SOB)	☐ Loss of consciousness	
☐ r/o A-fib/ Flutter	☐ Syncope	☐ Head injury	

Clinical details: (Seizures, age at onset, pattern, frequency, blackouts, LOC, date of head injury, surgery, stroke etc.)

Consultation Date:

Current medications:

☐ ASA (Aspirin) ☐ Other:
☐ ARB/ACE Inhibitor
☐ Statin
☐ Oral anticoagulants

Please Indicate (If present)	☐ Pacemaker ☐ Implanted Cardiac Defibrillator (ICD)

REFERRING PHYSICIAN INFORMATION	
Referring Physician:	Copy to:
Billing #: CPSO #:	Tel #: Fax #:
Tel #: Fax #:	
Signature:	Date: