CARDIAC DIAGNOSTIC REQUISITION

FOURTH AVENUE CARDIAC CLINIC
www.drschiew.com

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SELECT CONSULT URGENCY:
□ URGENT (< 2 WEEKS)
□ ELECTIVE (>2 WEEKS)

PATIENT NAME:_____

ADDRESS:_____

CITY:_____POSTAL CODE:_____

PHONE:_____DOB(Y/M/D):_____/_____/_____

HEALTH CARD #:_____

FOR AGE 18 AND ABOVE:

□ CARDIAC CONSULTATION

□ ECHOCARDIOGRAM

□ TREADMILL STRESS TEST
(CONSULTATION REQUIRED)

□ TREADMILL STRESS ECHO
(CONSULTATION REQUIRED)

FOR AGE 18 AND ABOVE:

□ ECG

□ HOLTER MONITOR:

□ 48 HR □ 72 HR

□ NOVI MONITOR (EXTENDED HOLTER):

□ 2 WEEKS

FOR PREOPERATIVE ECHOCARDIOGRAM
INDICATED SCHEDULED O.R. DATE:

_____

FOR PROSTHETIC VALVE ECHO ASSESSMENT SPECIFY SIZE, POSITION, MECHANICAL OR BIOPROSTHETIC VALVE (IF KNOWN:

_____

CLINICAL INFORMATION (please attach relevant information/reports):_____

_____

_____

REFERRING PHYSICIAN:_____BILLING No:_____

SIGNATURE:_____ COPY REPORT TO:_____

PHONE:_____FAX:_____DATE:_____