CARDIAC DIAGNOSTIC REQUISITION

FOURTH AVENUE CARDIAC CLINIC

www.drschiew.com

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CONSULT APPOINTMENTS ARE BOOKED AS NEXT AVAILABLE. PLEASE ENSURE YOUR PATIENT KNOWS TO VISIT THE ER OR CALL 911 IF THEY EXPERIENCE ANY UNSTABLE SYMPTOMS.

PATIENT NAME:_____

ADDRESS:_____

CITY:_____POSTAL CODE:_____

PHONE:_____ CELL:_____

DOB (Y/M/D):_____/_____/_____GENDER:_____

HEALTH CARD No#:_____ VC:_____

FOR AGES 18 AND ABOVE ONLY:

- ☐ CARDIAC CONSULTATION
- ☐ ECG
- ☐ ECHOCARDIOGRAM
- ☐ HOLTER MONITOR:
- ☐ TREADMILL STRESS TEST (**CONSULTATION REQUIRED**)
- ☐ 48 HR ☐ 72 HR
- ☐ TREADMILL STRESS ECHO (**CONSULTATION REQUIRED**)
- ☐ 2 WEEK

FOR PREOPERATIVE ECHOCARDIOGRAM INDICATE 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:_____