CARDIAC DIAGNOSTIC REQUISITION

Kawartha Cardiology
327 Charlotte Street Peterborough, Ontario, K9J 0B2
Phone: 705-740-6888 Fax: 705-749-9611

PATIENT INFORMATION or PLACE LABEL				
Name:		**Age/Gender:**	**Height (inches)**	**Weight (lbs)**
Date of Birth (dd/mm/yy):		**Health Card Number:**		
Address:		**Family Physician:**		
		Copy to:		
Home Phone:	**Mobile Phone:**	**Patient Pregnant or Breastfeeding?** ☐ **No** ☐ **Yes**		

URGENCY	**For internal use only:**
☐ Urgent ☐ Next Available ☐ Elective	☐ CP Clinic ☐ RAC/TIA Clinic ☐ HF Clinic

TO SCHEDULE AN APPOINTMENT, FAX THE REQUISITION TO 705-749-9611

EXAMINATION REQUESTED	**PATIENT PREPARATION/INFORMATION (Please read and follow)**	**OFFICE USE ONLY Date & Time**
☐ **Transthoracic Echo** ☐ **Bubble Study** **Indication:**	• No preparation	
☐ **TEE (Transesophageal Echo)** **Indication:**	• Patient will be contacted with instructions	
☐ **Stress Echocardiogram** ☐ **Exercise/Treadmill OR** ☐ **Dobutamine** Is patient on Beta blockers or Diltiazem? ☐ Yes ☐ No Does the patient have AFIB? ☐ Yes ☐ No **Indication:**	• Bring list of current medications • Wear loose clothing and comfortable shoes • **If Patient on Beta blockers / Diltiazem,** **STOP 48 Hours** prior to appointment: ☐ Yes ☐ No	
☐ **Exercise Stress Test (treadmill only)** Is patient on Beta blockers or Diltiazem? ☐ Yes ☐ No **Indication:**	• See Stress Echo instructions	
☐ **Holter** ☐ 24 hour ☐ 48 hour ☐ 72 hour ☐ 14 day **Indication:**	• No preparation	
☐ **ABP** ☐ 24 hour **Indication:**	• No preparation. Not covered under OHIP. Patient fee.	

HISTORY: (MUST BE PROVIDED)

Referring Physician:		**Date(dd/mm/yy):**
Signature:		**Office Phone:**
OHIP Billing #:	**CPSO #:**	**Fax Number:**

Incomplete requisitions will not be accepted.