Place Patient Label here

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

Appointment Date:
Appointment Time:

CARDIAC DIAGNOSTIC REQUISITION

PATIENT INFORMATION

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

URGENCY

☐ Urgent ☐ Next Available ☐ Elective

For internal use only:

☐ 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)
☐ **Transthoracic Echo** ☐ **Bubble Study**	• No preparation
☐ **TEE (Transesophageal Echo)**	• Patient will be contacted with instructions
☐ **Stress Echocardiogram** ☐ **Exercise/Treadmill** Is patient on Beta blockers or Diltiazem? ☐ Yes ☐ No ☐ **Dobutamine** Is patient on Beta blockers or Diltiazem? ☐ Yes ☐ No Does the patient have AFIB? ☐ Yes ☐ No	• 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	• See Stress Echo instructions
☐ **Holter** ☐ 24 hour ☐ 48 hour ☐ 72 hour ☐ 14 day	• No preparation
☐ **ABP** ☐ 24 hour	• No preparation. Not covered under OHIP. Patient fee.

INDICATION/QUESTION: (MUST BE PROVIDED)	**HISTORY: (MUST BE PROVIDED)**

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

Incomplete requisitions will not be accepted.