London Health Sciences Centre

NON INVASIVE CARDIOLOGY REQUISITION FOR DIAGNOSTIC TEST

☐ UNIVERSITY HOSPITAL	☐ VICTORIA HOSPITAL
519-663-3250	519-685-8500 ext. 55840
Fax: 519-663-3806	Fax: 519-685-8084

☐ OP ☐ IP ☐ RESEARCH: CRIC # _____

☐ SELF PAY ☐ OUT OF PROVINCE/COUNTRY ☐ MILITARY

☐ WSIB Employer: _____

ORDERING PHYSICIAN (please print): _____

FAMILY PHYSICIAN: _____

APPOINTMENT DATE: _____ TIME: _____

REQUEST ONLY ONE TEST PER REQUISITION

☐ ELECTROCARDIOGRAM (ECG/EKG)	☐ TREADMILL STRESS TEST	☐ 24 HOUR HOLTER	☐ ECHOCARDIOGRAM
☐ SIGNAL AVERAGED ECG	☐ BICYCLE STRESS TEST	☐ 48 HOUR HOLTER	☐ TEE (Transesophageal)
☐ TELEMETRY	*Risk Category*	☐ LOOP RECORDER	☐ Saline (Bubble) Study
☐ PACEMAKER ANALYSIS	☐ High ☐ Medium ☐ Low	☐ EVENT RECORDER	☐ Contrast Study
	Protocol: _____		☐ ECHO - Fetal

CLINICAL INFORMATION MUST BE PROVIDED OR TEST WILL BE DELAYED.

PRECAUTIONS: ☐ Contact ☐ Droplet ☐ Airborne ☐ Other: _____

_____

_____

_____

_____

_____

_____ Physician's Signature: _____

Lab Use Only (Echo Billing):			
☐ Transthoracic Echocardiogram ☐ 2D ☐ M-Mode ☐ Doppler	☐ Transesophageal Echocardiogram ☐ 2D ☐ M-Mode ☐ Doppler	☐ Saline Study ☐ Contrast Study	Weight: _____ Height: _____

Date Completed: _____ Time: _____ Technician: _____ Interpreted by: _____

8460-0343 (Rev. 2013/10/31)

London Health Sciences Centre

NON INVASIVE CARDIOLOGY REQUISITION FOR DIAGNOSTIC TEST

☐ UNIVERSITY HOSPITAL 519-663-3250 Fax: 519-663-3806

☐ VICTORIA HOSPITAL 519-685-8500 ext. 55840 Fax: 519-685-8084

☐ OP ☐ IP ☐ RESEARCH: CRIC # _____

☐ SELF PAY ☐ OUT OF PROVINCE/COUNTRY ☐ MILITARY

☐ WSIB Employer: _____

ORDERING PHYSICIAN (please print): _____

FAMILY PHYSICIAN: _____

APPOINTMENT DATE: _____ TIME: _____

REQUEST ONLY ONE TEST PER REQUISITION

☐ ELECTROCARDIOGRAM (ECG/EKG)
☐ SIGNAL AVERAGED ECG
☐ TELEMETRY
☐ PACEMAKER ANALYSIS

☐ TREADMILL STRESS TEST
☐ BICYCLE STRESS TEST
Risk Category
☐ High ☐ Medium ☐ Low
Protocol: _____

☐ 24 HOUR HOLTER
☐ 48 HOUR HOLTER
☐ LOOP RECORDER
☐ EVENT RECORDER

☐ ECHOCARDIOGRAM
☐ TEE (Transesophageal)
☐ Saline (Bubble) Study
☐ Contrast Study
☐ ECHO - Fetal

CLINICAL INFORMATION MUST BE PROVIDED OR TEST WILL BE DELAYED.

PRECAUTIONS: ☐ Contact ☐ Droplet ☐ Airborne ☐ Other: _____

_____ Physician's Signature: _____

Lab Use Only (Echo Billing):
☐ Transthoracic Echocardiogram ☐ 2D ☐ M-Mode ☐ Doppler
☐ Transesophageal Echocardiogram ☐ 2D ☐ M-Mode ☐ Doppler
☐ Saline Study ☐ Contrast Study
Weight: _____ Height: _____

Date Completed: _____ Time: _____ Technician: _____ Interpreted by: _____

8460-0343 (Rev. 2013/10/31)