STEVENSON
MEMORIAL HOSPITAL

200 Fletcher Crescent, Alliston, Ontario L9R 1W7

☐ **INPATIENT FAX: 5219**

TO BOOK AN APPOINTMENT:
Phone: 705-434-5133
Fax: 705-434-5111
Please bring a copy of the requisition with you to your appointment

CARDIOVASCULAR + RESPIRATORY TESTING REQUISITION

Name: PRINT CLEARLY OR USE PATIENT LABEL	**Health Card #:**
Address:	
Phone #:	**DOB:** (DD/MM/YY)

CARDIOLOGY DIAGNOSTICS

☐ Echocardiogram – greater than 6 yrs ☐ *Insured meets OHIP eligibility criteria*
Appt Date / Time ________

☐ Echocardiogram with agitated saline – Adult (Bubble Study)

☐ Contrast Echocardiogram – Adult (at discretion of cardiologist)
☐ Wall motion analysis
☐ Assessment for atypical thrombus

☐ Exercise Graded ECG stress greater than 18 years
Appt Date / Time ________

☐ 24 HR blood pressure monitor – $50
Appt Date / Time ________

☐ 24-HOUR HOLTER ☐ 7 DAY HOLTER
☐ 48-HOUR HOLTER ☐ 14 DAY HOLTER
☐ 72-HOUR HOLTER
Appt Date / Time ________

☐ **Cardiology Consultation greater than 18 years**

☐ **IF CARDIOLOGY CONSULT RECOMMENDED in report please arrange for consultation**

PULMONARY FUNCTION TESTING

☐ Pre-flow-loop (spirometry) greater than 6yrs

☐ Pre and Post flow-volume loop greater than 6yrs

☐ ABG

☐ 6 minute walk test

Appt: ________

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CLINICAL INFORMATION / TEST INDICATION:

Ordering Physician:	**Signature:**
Billing #:	**Date:**
CC:	

H-CARRTR

SM0014-14 December 2017