200 Fletcher Crescent, Alliston, Ontario L9R 1W7

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

☐ **INPATIENT FAX: 5219**

CARDIOVASCULAR + RESPIRATORY TESTING REQUISITION

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

CARDIOLOGY DIAGNOSTICS	PULMONARY FUNCTION TESTING
☐ 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 ☐ 14 DAY HOLTER ☐ 48-HOUR HOLTER ☐ 72-HOUR HOLTER Appt Date / Time___________________________ ☐ **Cardiology Consultation greater than 18 years**	☐ Pre-flow-loop (spirometry) greater than 6yrs ☐ Pre and Post flow-volume loop greater than 6yrs ☐ ABG ☐ 6 minute walk test Appt:___________________________ ___________________________

CLINICAL INFORMATION / TEST INDICATION:

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

H-CARRTR

SM0014-16 June 2020