



Capital Health

Cardiac Diagnostic Requisition

1796 Summer Street, Halifax, NS, B3H 3A7
325 Pleasant Street, Dartmouth, NS B2Y 4G8

Dartmouth General

Fax: (902) 465-8489
Phone: (902) 465-8302

QEII and Cobequid

ECG, Loop, Holter, Tilt Table, Stress test
Echocardiography
Echocardiography - Inpatient VG only

Fax: (902) 473-8518
Fax: (902) 473-2973
Fax: (902) 473-1484

Patient Identification:

<input type="checkbox"/> In-Patient	Unit _____	<input type="checkbox"/> Out-Patient	
Name: _____		Phone #: _____	
Address: _____			
DOB (YYYY/MM/DD): ____/____/____		Sex: _____	HUN: _____
Health Card #: _____		Expiry date (YYYY/MM/DD): ____/____/____	

Cardiac Exam Requested - Request only 1 exam per requisition:

Echocardiography

URGENT: (Justify below)

- Echo (Transthoracic)
- TEE (Transesophageal)
- Pharm. Stress Echo (Dobutamine)
- Exercise stress echo
- Amyl Nitrate required
- Assessment of dyssynchrony
- Other _____

Stress Testing

URGENT: (Justify below)

- Bruce
- Modified Bruce
- Naughton
- Other _____
- Rehab:
 - Slow Ramp
 - Regular Ramp
 - Fast Ramp
 - Symptom limited

Arrhythmia Monitoring

URGENT: (Justify below)

- ECG
- Holter
- Loop
- Tilt Table Test
- Signal Averaged ECG

Clinical Information: Indicate all relevant clinical details and specifically what information you wish to obtain. **Requisitions without adequate information will be returned without a booking and will have to be resubmitted.**

Please Note: Booking priority is based in clinical information provided. If faxing this requisition, do not send the original. Due to wait times, some in-patients may not be done before discharge. The attending physician should decide if out patient booking is required.

Referring Physician: _____	Physician tel #: _____
Signature: _____	Physician fax #: _____
<input type="checkbox"/> Research - Cost Centre #: _____	

