



**Syncope Remote Real-Time
Heart Monitor Requisition Form**

PATIENT INFORMATION (LABEL)

Name (Last, First)			Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other
Address		Unit	Home Phone
City	Province	Postal Code	Cell Phone
Health Card Number		Version Code (if applicable)	DOB (MM/DD/YYYY)

REFERRING HEALTH CARE PROVIDER INFORMATION

Name			Referrer's Signature
Billing #	Tel #	Fax #	Date (MM/DD/YYYY)
Copy Report to:			Fax #

THE CANADIAN SYNCOPE RISK SCORE

Category	Points	Total score	Risk category	Estimated risk of serious adverse events
Predisposition to vasovagal symptom	-1	-3 to -2	Very Low	Less than 1 %
History of heart disease	1	-1 to 0	Low	Less than 2 %
SBP < 90 or > 180 mmgh	2	1-3	Medium	3-8 %
Positive troponin	2	4-5	High	13-30%
LAD or RAD	1	6-11	Very High	29-80%
QRS > 130 ms	1	Total Score (-3 to 11) _____		
QTc > 480 ms	2			
Vasovagal syncope	-2			
Cardiac syncope	2			

CURRENT MEDICATION(S)

<input type="checkbox"/> Antiarrhythmic	<input type="checkbox"/> Ca Channel Blocker
<input type="checkbox"/> Anticoagulant	<input type="checkbox"/> Other: _____
<input type="checkbox"/> ASA	_____
<input type="checkbox"/> Beta-Blocker	_____
DEVICE(S)	<input type="checkbox"/> Pacemaker <input type="checkbox"/> Defibrillator

TEST DURATION

<input type="checkbox"/> 7-Day	<input type="checkbox"/> 14-Day
ANONYMOUS DATA COLLECTION <i>for quality improvement & research</i>	
<input type="checkbox"/> Patient Contacted	Verbal Consent <input type="checkbox"/> Yes <input type="checkbox"/> No
Staff Initials _____	Date _____

REF: CCC-CAL-SYCREQ-2024

Please Fax Requisition to: 587-475-8538