



**Real-Time 14-Day Home Heart Monitor Requisition
for Early A-Fib Detection & Stroke Prevention**

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 #

REASON FOR REFERRAL

Rule Out A-Fib / Flutter
 TIA / Stroke*
 Other: _____
 Syncope / Presyncope
 Seizure

*N Engl J Med 2014; 370:2467-2477 June 26, 2014

CURRENT MEDICATION(S)

Antiarrhythmic Ca Channel Blocker
 Anticoagulant Other: _____
 ASA
 Beta-Blocker

CONSENT

Allow monitoring team to begin anticoagulation therapy if A-Fib has been detected after hours

ANONYMOUS DATA COLLECTION
 for quality improvement & research
 Patient Contacted Verbal Consent Yes No

 Staff Initials _____ Date _____

DEVICE(S) Pacemaker Defibrillator

REF: CCC-CAL-TIAREQ-2024

Direct to Patient's Home



You request a monitor



We mail the monitor directly to the patient



Patient attaches monitor
(instructions provided)



We arrange the monitor return via pre-paid envelope

Please Fax Requisition to: 587-475-8538