CANADIAN CARDIAC CARE
Global Cardiovascular Risk Management
BRITISH COLUMBIA

miniHolter PLUS
HOME HOLTER REQUISITION

PATIENT INFORMATION (LABEL)

Name (Last, First)			Gender ☐ Male ☐ Female ☐ 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

- ☐ Dizziness
- ☐ Syncope
- ☐ Lightheaded
- ☐ TIA / Stroke*
- ☐ Palpitation

*J Am Coll Cardiol 2024; Oct: DOI:10.1016/j.jacc.2024.10.100

- ☐ Other: _____

CURRENT MEDICATION(S)

- ☐ No Medications
- ☐ ASA
- ☐ Antiarrhythmic
- ☐ Beta-Blocker
- ☐ Anticoagulant
- ☐ Ca Channel Blocker
- ☐ Other: _____

DEVICE(S)

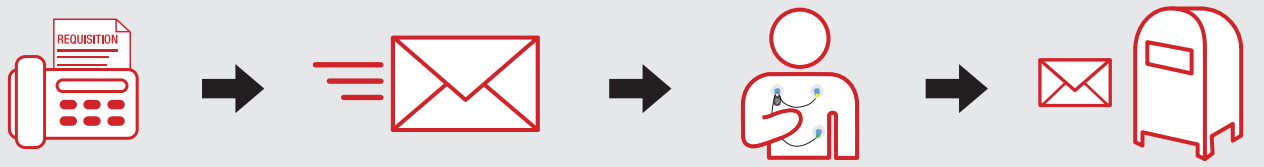
- ☐ Pacemaker
- ☐ Defibrillator

TEST DURATION

- ☐ 1-Day
- ☐ 5-Day

REF: CCC-BC-HHREQ-2026.08

Direct to Patient's Home



1: Request
You send requisition

2: Monitor Mailed
Directly to patient

3: Monitor Attached
Patient self-hookup

4: Monitor Returned
Via pre-paid envelope

Please Fax Requisition to: 1-877-469-2328

9842 101 Ave | Fort St. John, BC V1J 2B2 | T: 1-855-404-5667 | F: 1-877-469-2328