CANADIAN CARDIAC CARE
Global Cardiovascular Risk Management
BRITISH COLUMBIA

HOLTER REQUISITION ENROLLMENT & LOAN FORM

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 #

SYMPTOM(S)

☐ 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
☐ Implanted Cardiac Device

TEST DURATION

☐ 1-Day ☐ 5-Day

OFFICE USE ONLY

PATIENT LOAN AGREEMENT

I, the borrower, understand that the equipment loaned is sensitive and valuable, and must be handled with care at all times. I understand that the following actions may result in damage to the device: *1) Submerging the unit in liquid (ie. bathing, swimming) or exposing unit to direct streams of water. 2) Dropping the device. 3) Any other action by the borrower that causes damage to the device.*

I must return the equipment in good working condition or pay a replacement fee of $3000. I understand the device is not life-saving and the lender is not responsible for technology failure or any personal injury caused by improper use.

Electronic Data Sharing: I understand that the information collected will be electronically shared with Canadian Cardiac Care for monitoring services and clinical research purposes. **By signing this document I acknowledge that I have read and understand the terms and conditions stated above.**

_____ _____

Patient's Signature (Equipment Borrower) **Date** (MM/DD/YYYY)

HOOKUP

Serial Number		
Hookup Date (MM/DD/YYYY)	Time (HH:MM) ☐ AM ☐ PM	Staff Initials

RETURN

Monitor Condition ☐ OK ☐ Damaged ☐ Other _____		
Return Date (MM/DD/YYYY)	Time (HH:MM) ☐ AM ☐ PM	Staff Initials

REF: CCC-BC-HREQ-2026.08

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

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