



miniHolter^{PLUS}
HOME HOLTER REQUISITION

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

CURRENT MEDICATION(S)

DEVICE(S)

<input type="checkbox"/> Dizziness <input type="checkbox"/> Lightheaded <input type="checkbox"/> Palpitation <input type="checkbox"/> Other: _____ _____	<input type="checkbox"/> Syncope <input type="checkbox"/> TIA / Stroke* <small>*N Engl J Med 2014; 370: 2467-2477 June 26, 2014</small>	<input type="checkbox"/> Antiarrhythmic <input type="checkbox"/> Anticoagulant <input type="checkbox"/> ASA <input type="checkbox"/> Other: _____ _____	<input type="checkbox"/> Beta-Blocker <input type="checkbox"/> Ca Channel Blocker	<input type="checkbox"/> Pacemaker <input type="checkbox"/> Defibrillator
				TEST DURATION <input type="checkbox"/> 3-Day <input type="checkbox"/> 7-Day

REF: CCC-CAL-HHREQ-2024

Direct to Patient's Home



Please Fax Requisition to: 587-475-8538