CANADIAN CARDIAC CARE
Global Cardiovascular Risk Management
FORT MCMURRAY BRANCH

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
- ☐ Other: ____________________

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

CURRENT MEDICATION(S)

- ☐ Antiarrhythmic
- ☐ Beta-Blocker
- ☐ Anticoagulant
- ☐ Ca Channel Blocker
- ☐ ASA
- ☐ Other: ____________________

DEVICE(S)

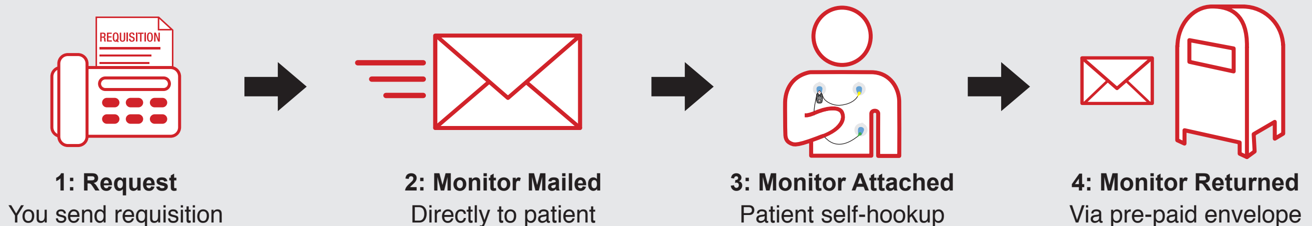
- ☐ Pacemaker
- ☐ Defibrillator

TEST DURATION

- ☐ 3-Day
- ☐ 7-Day

REF: CCC-FTMAC-HHREQ-2024

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: 780-743-3278

604-8600 Franklin Ave | Fort McMurray, AB T9H 4G8 | T: 780-743-3262 | F: 780-743-3278