CANADIAN CARDIAC CARE
Global Cardiovascular Risk Management
SASKATCHEWAN 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
- ☐ Lightheaded
- ☐ Palpitation
- ☐ Syncope
- ☐ TIA / Stroke*

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

- ☐ Other: ____________________

CURRENT MEDICATION(S)

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

DEVICE(S)

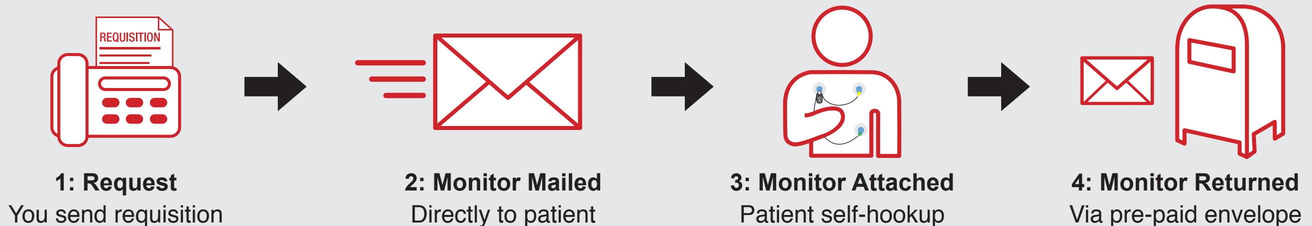
- ☐ Pacemaker
- ☐ Defibrillator

TEST DURATION

- ☐ 3-Day
- ☐ 7-Day

REF: CCC-SK-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: 306-691-5966

361 Main Street North | Moose Jaw, SK S6H 0W2 | T: 306-692-5066 | F: 306-691-5966