



HOLTER REQUISITION ENROLLMENT & LOAN FORM

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 #		

SYMPTOM(S)

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"/> Implanted Cardiac Device	TEST DURATION <input checked="" type="checkbox"/> 3-Day
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OFFICE USE ONLY

PATIENT LOAN AGREEMENT

I understand that the equipment loaned is sensitive and valuable. We require that all equipment be handled with care. The borrower understands 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.*

The borrower must ensure that the equipment is returned in working condition. I understand that the device is not life saving. The lender assumes no responsibility in case of technology failure or any personal injury sustained by improper use by the borrower.

Electronic Data Sharing: I understand the information collected will be electronically shared with Canadian Cardiac Care in order to fulfill monitoring services. **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

RETURN

Serial Number			Monitor Condition <input type="checkbox"/> OK <input type="checkbox"/> Damaged <input type="checkbox"/> Other _____		
Hookup Date (MM/DD/YYYY)	Time (HH:MM) <input type="checkbox"/> AM <input type="checkbox"/> PM	Staff Initials	Return Date (MM/DD/YYYY)	Time (HH:MM) <input type="checkbox"/> AM <input type="checkbox"/> PM	Staff Initials

REF: CCC-ON-HREQ-2024

Please Fax Requisition to: 1-844-329-5667