Niagara Health System
Système De Santé De Niagara

☐GNG	905-378-4647	Fax 905-358-7438
☐SCG	905-378-4647	Fax 905-684-6990
☐WHS	905-378-4647	Fax 905-732-9537

Cardiology Diagnostics Requisition

INCOMPLETE REQUISITIONS WILL BE RETURNED

Please PRINT patient information below. Please do not imprint.

MANDITORY					
	Surname		First Name		**Referring Physician**
	D.O.B.	Sex	H.C.N.		Name
	Referring Physician	Physicians to receive copies of report			Address
	Address		City		City Postal Code
	City		Postal Code		Phone
	Phone (home)		Phone (work)		Fax

ECG AND STRESS ECG

☐ **ECG (**No Preparation Required)

☐ **STRESS ECG** (At the St. Catharines Site, this study may be ordered by non-cardiologists)

Preparation for Stress ECG: Please have nothing to eat or drink for two hours before the test. Please wear comfortable clothing (ladies, please wear a two piece outfit with short sleeves) and walking/running shoes. Please bring a list of all of your medications.

Contraindications to Stress ECG

Severe Aortic Stenosis	Left Bundle Branch Block
Unstable Angina/Angina at rest	Patient unable to walk on the treadmill

HOLTER MONITORING

☐ **24 Hour Monitoring** ☐ **48 Hour Monitoring** **Other:** _____

No Preparation Required

AMBULATORY BLOOD PRESSURE MONITORING (St. Catharines Site ONLY)

☐ **AMBULATORY BLOOD PRESSURE MONITORING**

Preparation: There is a $50.00 charge for this study.
Prior to registering, please pay for the study at the Cashier's Office beside Patient Registration.

ECHOCARDIOGRAPHY

☐ Adult and Paediatric Echocardiogram (No Preparation Required)

☐ Other (please specify): _____

MYOCARDIAL PERFUSION IMAGING (Previous Stress ECG or Cardiologist Consult Required)

☐ Exercise (See preparation for Stress ECG)

☐ Persantine Is this patient Asthmatic? **Y** **N**

☐ Rest Thallium (Viability)

Medications

☐Beta Blockers ☐Ca Blockers ☐Nitrates

Other (specify)_____

Preparation: No caffeine for 24 hours. NPO for 4 hours.

Previous History and Findings – please include previous imaging and laboratory studies.

Physician's Signature:_____ **Urgent Results Contact:**_____

Appointment: Day [ ] Month [ ] Year [ ] **Time:** _____ ☐**GNG** ☐**SCS** ☐**WHS**