SERVICE REQUISITION FORM

Fax: (548) 561 - 0707

lub dub DIAGNOSTIC

Date of Request (yyyy-mm-dd)

PART 1: REQUESTED LOCATION

☐ Amherstburg – Amherstburg Clinical Specialist Center

☐ Paris – Brant Heart Clinic

PART 2: REQUESTED SERVICE (please check all that are required)

A. **Specialist Clinical Assessment**
- ☐ Cardiology Consultation
- ☐ Internal Medicine Consultation

B. Cardiac Diagnostic Testing
- ☐ Ambulatory Blood Pressure Monitor (ABPM)
- ☐ Resting 12-lead ECG
- ☐ Echocardiogram
- ☐ Holter Monitor
- ☐ Exercise Stress Test

If the **diagnostic test is <u>ABNORMAL</u>**, would you like us to arrange for a Specialist Consultation?

☐ Yes ☐ No

PART 3: PATIENT INFORMATION / LABEL IS ACCEPTABLE

Last Name	First Name	Date of Birth (yyyy-mm-dd)
Sex	Health Card No.	Version Code

Best Telephone No.

Please summarize the relevant patient's medical history or fax most recent clinical note. (required)

PART 4: MEDICAL PROVIDER INFORMATION

Type of Provider ☐ Family Physician ☐ Specialist ☐ Nurse Practitioner

Name of Referring Clinic

Telephone No.	Fax No.

Name of Physician / NP	Billing Number	Signature