

SERVICE REQUISITION FORM

Fax: (548) 561-0707



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 ABNORMAL**, 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.
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Name of Physician / NP 	Billing Number 	Signature 
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