Interior Health

OUTPATIENT CARDIAC DIAGNOSTIC REQUISITION

Patient Name *(last)* _____
       (first) _____

Address _____

Phone _____ Cell _____

PHN _____ DOB _____

☐ Female   ☐ Male   ☐ Other

Procedure Requested

☐ Resting ECG (**no appointment necessary**):
   ☐ ICBC   ☐ WSBC   ☐ Private

☐ Holter Monitor (24 hour)
   • Order includes baseline 12-lead ECG if unavailable on Intellispace server within last three months

☐ Event Monitor: ☐ 3 day   ☐ 5 day   ☐ 7 day   ☐ Other _____
   Atrial Fibrillation Detect: ☐ On   ☐ Off
       Auto Detect *(Optional):*   ☐ On   ☐ Off

Clinical Information (REQUIRED)   **Requests without clinical information will be returned**

Indication _____

Pertinent Cardiac History _____

Relevant Medications _____

Cardiac Device (i.e. Pacemaker, ICD):   ☐ Yes   ☐ No

Urgency

☐ P1 Emergent (if less than 24 hours) – call department

☐ P2 Urgent (within 7 days)

☐ P3 Semi-Urgent (within 30 days)

☐ P4 Routine (within 90 days)

☐ P5 Date Specific
     Indication _____

Physician / Nurse Practitioner Name *(print or office stamp)*	MSC Practitioner Number	Copy Results To
Office Phone	Specialty	
Signature	Date	

Appointment / Office Use Only

Date Requisition Received _____

Date Booked _____   Time _____

Date Complete _____   Time _____