



London Cardiac Institute

Diagnostic Test Requisition

Patient Information

Name:
Birthday:
Address:
City: Prov:
Postal Code: Phone:

Referring Physician Information

Name:
eMail:
Phone:
Fax:
OHIP Billing No:

Brief Medical History & Reason for Test (must be completed):

12 Lead ECG

Consultation with Exercise Stress Test

Exercise Stress Test only (no cardiac assessment or advice)

Holter Ambulatory Monitoring

24 Hr. 48 Hr.

Echocardiogram

Date: _____

Physician Signature: _____

For LCI use only

- | | | | |
|---|--|--|----------------------------------|
| <input type="checkbox"/> 394 Mitral Valve Disease | <input type="checkbox"/> 443 Peripheral Vascular Disease | <input type="checkbox"/> 435 Transient Cerebral Ischemia | <input type="checkbox"/> 432 CVA |
| <input type="checkbox"/> 785 Chest Pain NYD | <input type="checkbox"/> 398 Other Valve Disease | <input type="checkbox"/> 426 Heart Block | <input type="checkbox"/> |
| <input type="checkbox"/> 401 Hypertension | <input type="checkbox"/> 747 Aortic Valve Disease | <input type="checkbox"/> 412 Old MI, Stable CAD | <input type="checkbox"/> |
| <input type="checkbox"/> 441 Aortic Aneurysm | <input type="checkbox"/> 429 All Other Heart Disease | <input type="checkbox"/> 410 Acute MI | <input type="checkbox"/> |
| <input type="checkbox"/> 427 Other Arrhythmias | <input type="checkbox"/> 746 Congenital Heart Disease | <input type="checkbox"/> 413 Angina, ACI | <input type="checkbox"/> |

Scheduled Date:..... Time:.....

London Cardiac Institute
256 Pall Mall Street Suite 302, London, Ontario, N6A 5P6
519-645-0146 Fax 519-645-1584

Email: office@londoncardiac.ca Web Page: <http://www.londoncardiac.ca>

NOTE: The patient will be sent an appointment directly and a copy will also be emailed / faxed to the referring physician if the physician contact information is provided.