

Bloor St Pharmacy



849 Bloor St. W. Toronto, ON M6G 1M3
Tel: 416-537-4649 Fax: 416-519-2331

P A T I E N T I N F O	PATIENT'S LAST NAME
	PATIENT'S FIRST NAME
	HEALTH NUMBER
	TELEPHONE _____ DATE OF BIRTH _____ SEX _____ DAY MONTH YEAR M F

C L I N I C A L	
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PLEASE BRING THIS REQUISITION AND YOUR HEALTH CARD.

APPOINTMENT
DATE AND TIME: _____

Referred by: _____
Dr. Signature _____
Copy To: _____

STAT
 VERBAL

INDICATIONS FOR HOLTER MONITORING	
<input type="checkbox"/> Murmurs	<input type="checkbox"/> Chest pain
<input type="checkbox"/> Palpitations	<input type="checkbox"/> Heart condition increasing risk of arrhythmia - e.g. CAD
<input type="checkbox"/> Vertigo / dizziness	<input type="checkbox"/> Hypertension
<input type="checkbox"/> Syncope	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Ongoing fatigue / tiredness of unknown cause
<input type="checkbox"/> Arrhythmia on auscultation r/o Atrial Fibrillation	<input type="checkbox"/> Bradycardia / tachycardia
	<input type="checkbox"/> Pacemakers

CARDIAC DIAGNOSTICS
<input type="checkbox"/> Holter Monitoring
<input type="radio"/> 72 hour
<input type="radio"/> 1 week