TotalCardiology®
Your Heart. Your Health. For Life.

CARDIO-DIAGNOSTIC TEST REQUISITION FORM

Appointment Booking
Phone: 403 571 8640
Fax: 403 571 8658

Patient Information (please provide height and weight)

Last Name: _____ First Name: _____

Preferred Name: _____ Email Address: _____

DOB (mm/dd/yyyy): _____ PHN: _____ Daytime Phone: _____

Height: _____ ☐ cm ☐ ft/in Weight: _____ ☐ kg ☐ lbs

Sex: ☐ Male ☐ Female ☐ Unknown/choose not to disclose Gender Identity:

Referring Physician Information

Name: _____ Specialty: _____

PracID: _____ Phone: _____ Fax: _____

Location: ☐ ER Dept ☐ UrgentCare ☐ Clinic/Office

MPI + Exercise Stress Test

Have you asked your patient to hold anti-ischemic medications? ☐ Yes ☐ No

Does your patient have any of the following: ☐ Diabetes ☐ Asthma ☐ ICD ☐ CABG ☐ Pacemaker ☐ Angioplasty/stent

Is your patient: ☐ Asymptomatic ☐ Symptomatic: ○ Chest pain ○ Dyspnea ○ Other: _____

Pretest likelihood of CAD: ☐ Very low ☐ Low ☐ Intermediate ☐ High ☐ Known CAD

☐ **Myocardial Perfusion Imaging (MPI) Stress Test:** ○ Exercise ○ Pharmacologic

☐ **Exercise Stress Test (no imaging)**

- ○ Assess myocardial ischemia/infarction
- ○ Global cardiac risk stratification OR pre-op risk assessment for non-cardiac surgery
- ○ Abnormal exercise stress test
- ○ Assess exercise capacity/fitness level/HR + BP response
- ○ Assess for exercise-induced dysrhythmia

Office Use Only:

MPI or STRESS TEST Appointment Date + Time:

☐ **Echocardiogram**

- ○ Cardiac structure+ function
- ○ Valvular heart abnormalities
- ○ Adult congenital heart disease
- ○ Pericardial abnormalities
- ○ Cardiac source of embolus

ECHO Appointment Date + Time:

☐ **Carotid Doppler**

- ○ Syncope/pre-syncope
- ○ Endarterectomy/carotid stenting
- ○ TIA/Stroke
- ○ Evaluate carotid bruits

CAROTID Appointment Date + Time:

☐ **24-Hour Holter**

- ○ Syncope/pre-syncope
- ○ Known atrial fibrillation/ flutter
- ○ Palpitations
- ○ Suspected dysrhythmia

HOLTER Appointment Date + Time:

Provisional diagnosis/ Additional History

Copy reports to:

MD Signature/ Clinic Name/Stamp:

TOTALCARDIOLOGY
#110, 2891 Sunridge Way NE | Calgary, AB T1Y 7K7
totalcardiology.ca

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