CARDIO-DIAGNOSTIC TEST REQUISITION FORM

TotalCardiology®

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

Referring Physician Information:

Name:	
Specialty:	
PracID:	
Phone:	
Fax:	
Location: ☐ ER Dept	
☐ Urgent Care	
☐ Clinic/Office	
☐ Other	

Patient Information: (please provide height and weight)

Last Name:			
First Name:			
Preferred Name:			
Email Address:			
Daytime Phone:			
DOB (dd/mm/yyyy):		PHN:	
Sex: ☐ Male	☐ Female	☐ Unknown/choose not to disclose	
Gender Identity:			
Height:	☐ cm ☐ ft/in	Weight:	☐ kg ☐ lbs

MPI or Exercise Stress Test

OFFICE USE ONLY:
MPI or STRESS TEST
Appointment Date + Time:

☐ Myocardial Perfusion Imaging (MPI) Stress Test: ☐ Exercise Stress Test (no imaging)

○ Exercise ○ Pharmacologic

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

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

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

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

Indication:
- ☐ Assess myocardial ischemia/infarction
- ☐ Pre-op risk assessment for non-cardiac surgery
- ☐ Global cardiac risk stratification
- ☐ Assess exercise capacity/fitness level/HR and BP response
- ☐ Abnormal exercise treadmill test
- ☐ Assess for exercise-induced dysrhythmia

☐ Echocardiogram

☐ Bubble Study

- ☐ Cardiac structure and function
- ☐ Pericardial abnormalities
- ☐ Valvular heart abnormalities
- ☐ Cardiac source of embolus
- ☐ Adult congenital heart disease

ECHO Appointment
Date + Time:

☐ Carotid Doppler

- ☐ Syncope/pre-syncope
- ☐ TIA/stroke
- ☐ Endarterectomy/carotid stenting
- ☐ Evaluate carotid bruits

CAROTID Appointment
Date + Time:

☐ 1-Day Holter

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

HOLTER Appointment
Date + Time:

Provisional Diagnosis/Additional History:

Copy reports to:	MD Signature/ Clinic Name/Stamp

TOTALCARDIOLOGY
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