m-health SOLUTIONS

HOLTER REQUISITION

CLINIC/HOSPITAL

Referring Physician: _____

HCP Registration Number: _____

FAX REQUISITION TO: 1-888-636-0181

PATIENT INFORMATION		
Name		Gender: ☐ M ☐ F
Address	Unit	Phone: Cell: Home:
City	Postal Code	E-mail:
Health Card Number	Version Code	DOB
CC: Name	Fax number/ E-mail	

REASON FOR REFERRAL		CURRENT MEDICATION(S)	
☐ R/O A-Fib/Flutter	☐ Syncope	☐ ACE Inhibitor	☐ Pacemaker
☐ Known A-Fib/Flutter	☐ Palpitations	☐ ASA	☐ Implanted Cardiac Defibrillator
☐ TIA/ Stroke		☐ ARB	
☐ Chest Pain		☐ Beta Blocker	
☐ Dizziness		☐ Statin	
☐ Shortness of breath		☐ Oral Anticoagulant	
☐ Other:		☐ Other:	

Test Requested:

- ☐ 72-Hour Patch (Southern Ontario only)
- ☐ 2 Weeks
- ☐ Repeat 2 Weeks (To be done 1 month after)

Physician Signature: _____ Date: _____

Note: We must be in contact with your patient to confirm their shipping address prior to mailing the device.

BY AGREEING TO DO THIS TEST THE PATIENT ACKNOWLEDGES RESPONSIBILITY FOR THE DEVICE AND ITS SAFE RETURN. IF LOST OR DAMAGED WHILE IN THEIR POSSESSION, THEY ARE RESPONSIBLE FOR THE REPLACEMENT COST BETWEEN $725.00 AND $825.00

m-health SOLUTIONS
70 Frid Street, Unit 3
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Phone: 1-888-636-0186
www.m-healthsolutions.com

Cardiac Diagnostic Service