

CARDIOPULMONARY SERVICES

CARD/PULM.



Quinte Health

MD Name:	Patient Name:
Signature:	DOB:
MD Phone:	HCN:
Date: (d/m/y)	Home Phone:
Copies to:	Cell Phone
WSIB #:	Address:

FAX ALL REQUISITIONS TO:
613-969-5561

A BOOKING WILL NOT BE MADE UNLESS THIS REQUISITION IS COMPLETED IN FULL

CLINICAL INDICATION:

Please select all required Procedures

Select Preferred location

HOLTER MONITORING

Exam Available at:

<input type="checkbox"/> 24 Hour Holter	<input type="checkbox"/> BGH	<input type="checkbox"/> TMH	<input type="checkbox"/> PEC	<input type="checkbox"/> NHH
<input type="checkbox"/> 48 Hour Holter	<input type="checkbox"/> BGH	<input type="checkbox"/> TMH	<input type="checkbox"/> PEC	<input type="checkbox"/> NHH
<input type="checkbox"/> 3 Day Holter	<input type="checkbox"/> BGH	<input type="checkbox"/> TMH	<input type="checkbox"/>	
<input type="checkbox"/> 7 Day Holter	<input type="checkbox"/> BGH	<input type="checkbox"/> TMH		

CARDIAC STRESS TESTING

Exam Available at:

<input type="checkbox"/> Treadmill Stress Test	<input type="checkbox"/> BGH	<input type="checkbox"/> TMH
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Electrocardiogram (ECG)

Exam Available at:

<input type="checkbox"/> ECG (no appointment needed 9am-2pm)	<input type="checkbox"/> BGH	<input type="checkbox"/> TMH
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ECHOCARDIOGRAM

Exam Available at:

<input type="checkbox"/> Echo with Doppler	<input type="checkbox"/> BGH	<input type="checkbox"/> TMH	<input type="checkbox"/> PEC
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PULMONARY FUNCTION

Exam Available at:

<input type="checkbox"/> Full PFT- pre/post bronchodilator, Lung Volume, DLCO and RAW (Ages 12 and older)	<input type="checkbox"/> BGH	<input type="checkbox"/> TMH
<input type="checkbox"/> Spirometry Only- pre/post bronchodilator (Age < 12 years)	<input type="checkbox"/> BGH	<input type="checkbox"/> TMH
<input type="checkbox"/> Methacholine Challenge Test	<input type="checkbox"/> BGH Only	

*Must have PFT results within last 12-18 months completed at Quinte Health

*Ages >8 with acceptable spirometry

OXYGEN ASSESSMENT

Exam Available at:

<input type="checkbox"/> Independent Exercise Oximetry (IEA)	<input type="checkbox"/> BGH Only
<input type="checkbox"/> Arterial Blood Gas (ABG)	<input type="checkbox"/> BGH <input type="checkbox"/> TMH
<input type="checkbox"/> 6 minute Walk Test	<input type="checkbox"/> BGH Only

DEPARTMENT USE ONLY

Appointment Date & Time: _____

PLEASE ENSURE REQUISITION IS COMPLETE. FAX REQUISITION TO 613-969-5561