Bluewater
SLEEP DISORDER CLINIC

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1258 Michigan Ave SARNIA ON N7S 3Y2
519-332-5333
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REQUEST FOR CARDIAC TESTING

PATIENT INFORMATION:

Name ________________________________ **Height** ___________ **Weight** ___________ **M / F**

HCN _______________________ **Version** _______ **Birthdate** ____________________ **Age** _________

Home Phone _________________ **Cell Phone** ___________________ **Email** ____________________

Street ______________________________ **City** ____________________ **Postal Code** _____________

HEALTH CARE PROVIDER INFORMATION:

Name _____________________ **OHIP billing #** ____________________ **Phone** __________________

Fax _____________ **Email** _________________________ **Signature** ____________________________

Family Health Care Provider ______________________________ **Date** _________________________

Ambulatory Monitoring:

☐ Holter Monitor (24-72 hour) ☐ 24 Hour Ambulatory BP Monitor**

☐ 12 Lead ECG

Does the patient have a pacemaker?

☐ Yes ☐ No

Does the patient have any known Cardiac History?

☐ Yes ☐ No If yes, explain:

Indication for Testing:

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List of Medications:

***Please note a **$60.00 fee** will be charged to the patient for 24 hour Ambulatory Blood Pressure Monitoring.*

Note: Cancellations must be given at least 24 hours prior to scheduled appointments. Should notice not be given a no-show charge will be billed to the patient.