



Meadowlark Cardiac Lab

Phone: 780-669-2222 | Toll Free: 1-866-771-9446 | Fax: 780-930-1593
#234, 156 Street - 89 Avenue | Edmonton, Alberta T5R 5W9
Cardiac Stress Test | MIBI | CT Calcium | ECG | Holter | ABPM

Appointment:

Date	Time
MIBI Rest: _____	_____
Stress: _____	_____
ABPM or: _____	_____
Holter Setup: _____	_____
Return: Next day between 07:30 - 11:00	
Stress Test: _____	_____

NAME: _____

ADDRESS: _____ INSURANCE #: _____

PHONE: _____ DATE OF BIRTH: _____ M F

Please keep your appointment. If you don't cancel 24 hours prior to exam, you may be charged a \$25.00 fee. Remember that others with healthcare needs could use your appointment time.

CARDIAC EXAM REQUESTED

Please fax this completed requisition to 780-930-1593, and if available: resting ECG, recent history, consultation report, complete medication list, copy of previous Stress Test, Angiogram, and/or Echocardiogram.

- | | |
|--|--|
| <input type="checkbox"/> Exercise MIBI - Myocardial Perfusion Scan | <input type="checkbox"/> Holter Recording |
| <input type="checkbox"/> Persantine MIBI - Myocardial Perfusion Scan | <input type="checkbox"/> 24 Hour Ambulatory Blood Pressure Monitoring (not covered by AHCIP - payment required) (ABPM) |
| <input type="checkbox"/> Exercise Stress Test | |
| <input type="checkbox"/> Exercise Stress Test for Driver's Medical (not covered by AHCIP - payment required) | |

INDICATION

- | | |
|--|---|
| <input type="checkbox"/> Diagnosis of coronary disease | <input type="checkbox"/> Driver's License Qualification & Third Party Medical (not covered by AHCIP - payment required) |
| <input type="checkbox"/> Evaluation of extent & severity of coronary disease | <input type="checkbox"/> Risk stratification pre-op: Date _____ |
| <input type="checkbox"/> Investigation of patient with multiple risk factors | <input type="checkbox"/> Operation: _____ |
| | Other _____ |

CHEST PAIN

- | | | | | |
|------------------------------|--------------------------------------|---|-------------------------------------|----------------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> Typical | <input type="checkbox"/> New | <input type="checkbox"/> Exertional | <input type="checkbox"/> Dyspnea |
| <input type="checkbox"/> No | <input type="checkbox"/> Atypical | <input type="checkbox"/> Chronic | <input type="checkbox"/> Rest | <input type="checkbox"/> Syncope |
| | <input type="checkbox"/> Non-anginal | <input type="checkbox"/> Changing Pattern | <input type="checkbox"/> Nocturnal | |

CARDIAC

- | | | |
|--------------------------------------|--|--|
| <input type="checkbox"/> CABG | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Heart Failure |
| <input type="checkbox"/> Angioplasty | <input type="checkbox"/> Valvular Heart Disease* | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Stent | <input type="checkbox"/> Atrial Fibrillation | <input type="checkbox"/> Family History |
| <input type="checkbox"/> MI | <input type="checkbox"/> Cardiac Arrest | <input type="checkbox"/> Rheumatic Fever |
- * Stress testing not recommended if aortic stenosis is suspected

PULMONARY

- Asthma
- C.O.P.D.
- Interstitial Lung Disease
- Chest wall Abnormality

GENERAL

- | | |
|---|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Renal Failure |
| <input type="checkbox"/> Obesity | <input type="checkbox"/> Hepatitis / HIV |
| <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Peripheral Vascular Disease |
| <input type="checkbox"/> Hyperlipidemia | <input type="checkbox"/> Stroke |

MEDICATIONS

- | | |
|---|---|
| <input type="checkbox"/> Beta Blockers _____ | <input type="checkbox"/> Oral hypoglycemic agents _____ |
| <input type="checkbox"/> Calcium Channel Blockers _____ | <input type="checkbox"/> Bronchodilators _____ |
| <input type="checkbox"/> Nitro _____ | <input type="checkbox"/> Theophylline _____ |
| <input type="checkbox"/> Insulin _____ | <input type="checkbox"/> Other Medications _____ |

REFERRING PHYSICIAN

(Fill in or stamp)

NAME: _____

ADDRESS: _____

PHONE: _____ FAX: _____

SIGNATURE: _____

COPIES TO: _____

ADDRESS: _____

URGENT REPORT _____