WINDSOR REGIONAL HOSPITAL
OUTSTANDING CARE – NO EXCEPTIONS!

ELECTROCARDIOGRAM (EKG) REQUISITION

Fax Requests to:
Phone: (519) 254-1727 Fax: (519) 255-2125

INCOMPLETE REQUESTS WILL BE RETURNED

Patient Information (Please Print):

Name: _____ Date of Birth (mm/dd/yyyy): _____ Sex: ☐ M ☐ F

Address: _____ WSIB: _____ Patient's Weight: _____ lbs _____ Kgs

Primary Contact: ( )_____ Secondary# ( ) _____ Patient's Height: _____ ft _____ in

Health Card #: _____ Version Code _____ Patient arriving from external healthcare facility: ☐ Y ☐ N

☐ **12 Lead EKG** ☐ **Stress Test**

Clinical Indication:

- ☐ Arrhythmias
- ☐ Chest Pain NYD
- ☐ Decreased Heart Rate / Bradycardia
- ☐ Dizziness
- ☐ Dyspnea
- ☐ EKG Changes
- ☐ Palpitations
- ☐ Post MI Follow up
- ☐ Rapid Heart Rate / Tachycardia
- ☐ R10 Pacemaker Malfunction
- ☐ Syncopal Episodes
- ☐ Unstable Angina

Other:_____

Clinical Comments:

_____

_____

_____

List Current Medications:

_____

_____

_____

Interpreting Physician: _____**(If blank, will be referred to first available)**

Print Referring Physician:_____ Fax Number:_____

Copy to (Drs): _____

Referring Physician Signature: _____

APPOINTMENT:

DATE (mm/dd/yyyy)**:** _____ **TIME:** _____ **CAMPUS:** _____