

Cardiac Assessment Requisition



Radiology Consultants
ASSOCIATED

125, 40 Sunpark Plaza SE, Calgary, AB T2X 3X7

Appointments: 403.777.3000 or Toll Free 1.866.611.2665 (Hours: 7:30 am – 5:00 pm)

Note to Physicians: Once you've called to book your patient's appointment, please fax this completed requisition to **403.777.3148**, and if available include: resting ECG, complete medication list, copy of previous Stress Test, Angiogram, and/or Echocardiogram.

Exam Type

1. **Myocardial Perfusion Scan:**

Exercise Stress
 Pharmacologic Stress (Persantine)

2. **Exercise Stress Test**
(No Imaging)

PATIENT INFORMATION

Name: _____
Date of Birth Day: _____ Month: _____ Year: _____
Home: _____
Work: _____
Cell: _____

Gender: M F
Address: _____
City/Province: _____
Postal Code: _____
Insurance: _____

INDICATION

- | | |
|---|--|
| <input type="checkbox"/> Diagnosis of coronary disease | <input type="checkbox"/> Investigation of patient with multiple risk factors |
| <input type="checkbox"/> Cardiac function | <input type="checkbox"/> Pre-op risk stratification. Surgery date: _____ |
| <input type="checkbox"/> Evaluation of extent/severity of known coronary disease | <input type="checkbox"/> Operation: _____ |
| <input type="checkbox"/> Driver's license qualification & third party medical
(Not covered by AHCIIP – payment required) | <input type="checkbox"/> Other: _____ |

PATIENT HISTORY

Chest Pain

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

Cardiac

- | | |
|--|--|
| <input type="checkbox"/> CABG | <input type="checkbox"/> Atrial Fibrillation |
| <input type="checkbox"/> Angioplasty | <input type="checkbox"/> Cardiac Arrest |
| <input type="checkbox"/> Stent | <input type="checkbox"/> Heart Failure |
| <input type="checkbox"/> Myocardial Infarction | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Family History |
| <input type="checkbox"/> Valvular Heart Disease* | <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"/> Nitroglycerin: _____ | <input type="checkbox"/> Theophylline: _____ |
| <input type="checkbox"/> Insulin: _____ | <input type="checkbox"/> Other: _____ |

REFERRING PHYSICIAN'S INFORMATION

Name: _____
Signature: _____
Phone: _____ Fax: _____
Copy to: _____
Stat Report

Address: _____

Patient Instructions

- We will contact you prior to your exam to review instructions with you. Should you have any questions in the meantime, please do not hesitate to call us at 403.777.3000.
- **Please bring a copy of this requisition form** to your appointment.
- Arrive at 125, 40 Sunpark Plaza SE, **15 minutes prior to your appointment**. If you are late, your examination may have to be postponed to a later date.
- **DO NOT EAT or DRINK** for four hours prior to test.
- **No caffeine-containing foods or beverages** (includes coffee, tea, pop, chocolate and **medication with caffeine such as Tylenol #3 or Excedrin** for 24 hours prior to the test).
- **Wear comfortable clothing** and appropriate footwear for walking on the treadmill. Preferably wear a short sleeved shirt with buttons or an oversized T-shirt.
- Continue taking all medications unless otherwise instructed by your physician. **Bring all current medications with you.**
- **No barium studies** 48 hours prior to this examination.
- **Please do not wear perfumes/colognes** or any scented products to your appointment.

Myocardial Perfusion Scan

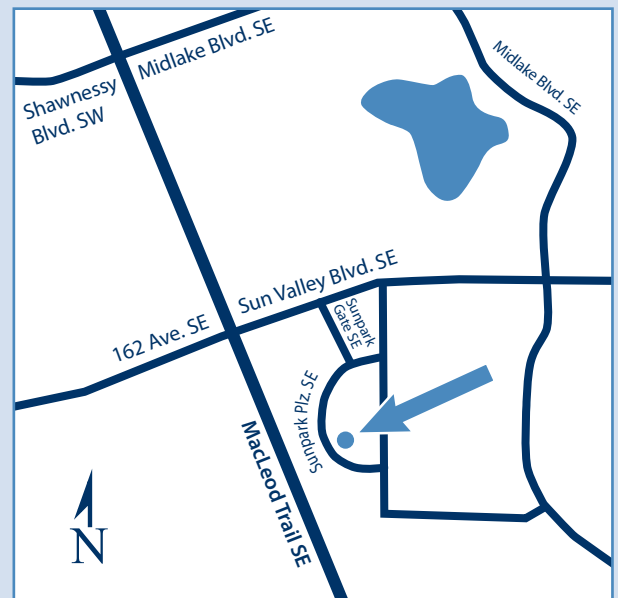
- The heart is imaged in two different phases; on one day after resting (allow two hours), and on a different day after exercise or pharmacologic stress (allow three hours).

Exercise Stress Test

- Allow 1.5 hours.

APPOINTMENT REMINDER AND LOCATION

	Date	Time
Myocardial Perfusion Scan		
Resting Phase:	_____	_____
Stress Phase:	_____	_____
Exercise Stress Test	_____	_____



Rev. July 1/06



**Radiology
Consultants**
ASSOCIATED

125, 40 Sunpark Plaza SE
Calgary, AB T2X 3X7
Central Booking: 403.777.3000
Toll Free: 1.866.611.2665

Diagnostic MRI & CT Exams.
Without the wait.

- Coronary Calcium Scoring
 - Preventative CT Health Assessments
- 777.4MRI (4674) • 1.866.777.7570
Calgary • www.mayfairdiagnostics.com



MAYFAIR™
DIAGNOSTICS