

SUNNYBROOK HEALTH SCIENCES CENTRE  
2075 Bayview Avenue, Suite E-248  
Toronto, ON Canada M4N 3M5  
T: 416-480-6100 ext. 4470  
F: 416-480-5740  
[www.sunnybrook.ca](http://www.sunnybrook.ca)

**HOLTER REQUISITION**

Check   24 Hour  48 Hours  
 INPATIENT  OUTPATIENT: (suggest timeline) \_\_\_\_\_

**REASON FOR REFERRAL:**

STROKE: r/o atrial fibrillation (24 Hours is recommended standard, 48 Hours if clinically indicated)

- If inpatient request, please book < 72 hours from requisition date
- If outpatient request, please book < 2 weeks from requisition date

Palpitations  Dizziness  Presyncope  Assessment of therapy  
 Myocardial Infarction  Post MI  
 Pacemaker function: Type (if known) \_\_\_\_\_  
 Dual Chamber  Single Chamber  Rate Response

Summary of History and Findings:

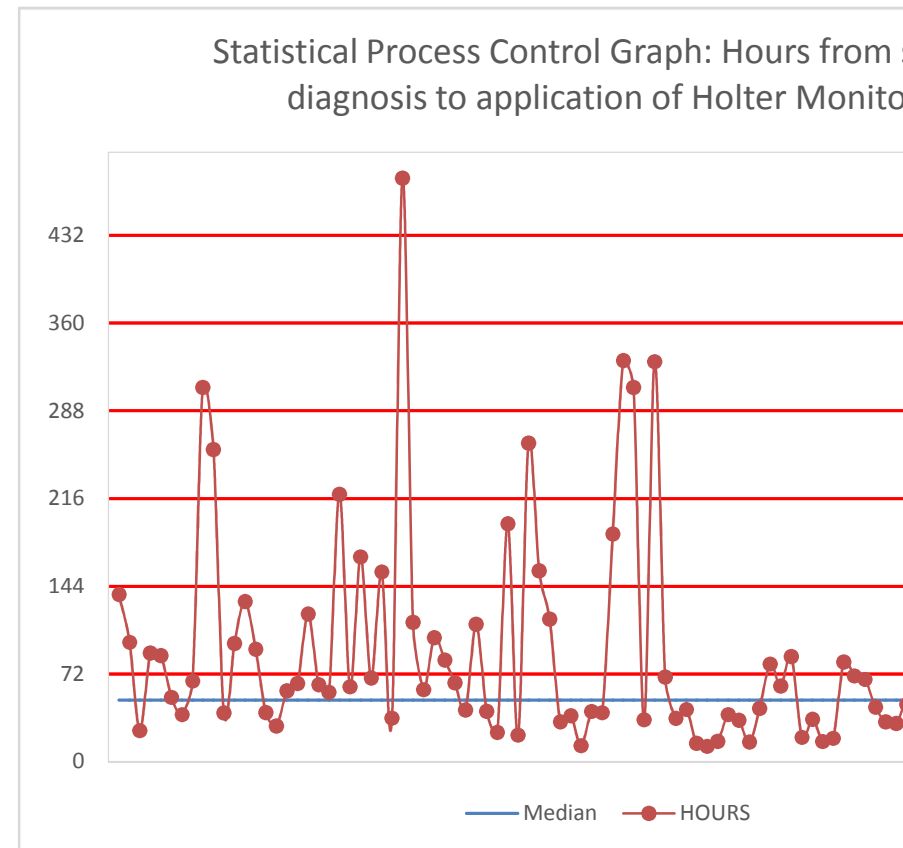
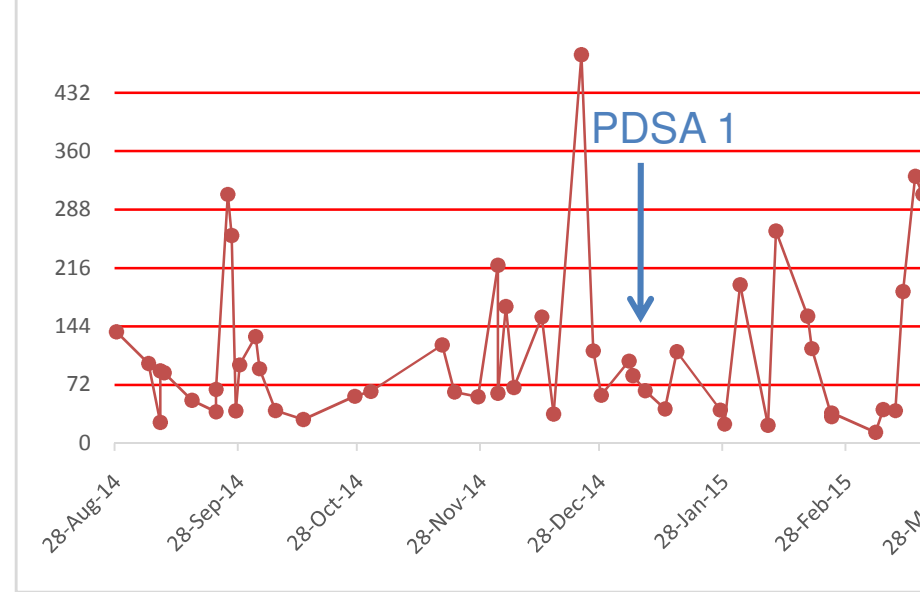
Previous ECG:  Yes  No  
Digitalis:  Yes  No

Referring MD:

\_\_\_\_\_  
(print name) (signature) Pager ID: \_\_\_\_\_

Date ordered: \_\_\_\_\_ Time ordered: \_\_\_\_\_

Fax requisition to 416-480-5740: Date faxed: \_\_\_\_\_ Time faxed: \_\_\_\_\_



ED

circulation  
request for stroke (initial form did not mention