

Myant SKIIN™ Cardiac Monitoring Requisition Form

Holter Study

Fax requisition to 1-866-356-1639

MYANT HEALTH INC.
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Mississauga, ON, CA, L5K 2L1
Phone: 1-844-722-9977
Fax: 1-866-356-1639
support@myant.ca



Clinic & Study Details

Clinic name: _____

Clinic address: _____

Clinic primary contact name: _____ Clinic email address: _____

Clinic phone: _____ Clinic fax: _____

Name of referring physician: _____

Study duration: ☐ 72 hours ☐ 7 days ☐ 14 day Billing code: _____

Licence #: _____

☐ Request virtual consult for the patient if an abnormal result is identified

Patient Information

Name: _____ Sex: ☐ Male ☐ Female

Address: _____ Cell phone: _____

(Line 2): _____ Home phone: _____

Unit #: _____ Email address: _____

City: _____ DOB (YYYY-MM-DD): _____

Postal code: _____

Health card number/ version code: _____

Patient consent for contact preference

☐ Patient accepts the privacy risks associated with receiving study information and equipment via cellular, email, and postal mail.

Reasons for Test

Clinical Categorization

- ☐ R/O A-FIB/FLUTTER
- ☐ KNOWN A-FIB FLUTTER
- ☐ TIA/STROKE
- ☐ CHEST PAIN
- ☐ DIZZINESS
- ☐ SHORTNESS OF BREATH
- ☐ SYNCOPE
- ☐ PALPITATION
- ☐ OTHER

Current Medication(s)

- ☐ ACE INHIBITOR
- ☐ ASA Acetylsalicylic Acid
- ☐ ARB Angiotensin II Receptor Blockers
- ☐ BETA BLOCKER
- ☐ STATIN
- ☐ ORAL ANTICOAGULANT
- ☐ OTHER: _____

Device Categorization

Please confirm the patient **does not** have any of the following:

- ☐ Pacemaker / Implantable Cardiac Defibrillator
- ☐ Pregnant
- ☐ <18 years of age

Authorization

☐ I am the referring clinician, or I am completing this referral on their instruction. The clinical information here is accurate to the best of my knowledge, and I am responsible for it. The patient has agreed to this study and to Myant Health receiving the information on this form in order to provide it.

Holter start date (YYYY-MM-DD): _____ Date requisition sent to Myant (YYYY-MM-DD): _____

Physician signature: _____