

Electrodiagnostic Services Request for Exam

Date of Birth:

MRN:

Name:

PHN:

		Phone Numb	or.
Urgency: RoutineASAPSTAT (Considered routine if not indicated)		In-Patient Unit_	
Physician Information			
Requisition Date:			
Date Required:	Additional Copies: _		
Ordering Physician :(No Residents)	SIGNATURE		MSC#
Pacemaker Clinic Exam Requests O/P Regular (IP/OP) Requests RJH – Phone: 250-370-8670 Fax 250-370-8658 *please include REASON for exam request below Inpatient EDS Contact Information	r Hours Monday–Friday Type of	· _	ICD (Defibrillator)
RJH- Ph: 250-370-8231 (regular business hours Monday - VGH- Ph: 250-727-4200 (regular business hours Monday	– Friday 07:30 − 15:30 hr) o	r 2 Way Radio Loc	
RJH or VGH © ECG (Electrocardiogram) I/P call department or 2 way radio O/P Give req to outpatient - no booking required © Treadmill - VGH (O/P Fax to 250-727-4083)	PH only (Fax to 250-652-758 24-Hour Holter Scan 48-Hour Holter Scan JH only (Fax to 250-370-865 Ambulatory BP Monitoring (Outpatient only)	WGH or □ Ev G.I. VGI □ Es □ 24 Urodyn □ Pre	nly (Fax to 250-727-4368) ent Monitoring (Outpatient only) H (Fax to 250-727-4240) ophageal Motility Hr. pH Probe namics VGH only (Fax to 250-727-4240) essure Flow Study (Cysto) iding Flow
Brief Relevant Reason REQUIRED			
Precautions:			

For Office Use Only: