MEDIGROUP CARDIO+

Medigroup Cardio+
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Graded Exercise Test Requisition

Patient name: _____ DOB: _____

MH #: _____ PHIN #: _____

☐ Male ☐ Female ☐ Other _____ Email: _____

Address: _____

Phone: home/cell _____ work _____

Referring provider name: _____

Clinic/hospital: _____ Date: _____

Address: _____

Phone: _____ Fax: _____

INDICATION FOR GXT

☐ Chest Pain
☐ Dyspnea
☐ CV Assessment (high-risk individual - DM2/dyslipidemia/HTN/smoking/age>50)
☐ Arrhythmia Provocation
☐ Functional Exercise Assessment
☐ Post-MI Risk Stratification
☐ Risk Stratification for HOCM
☐ Arrhythmia Treatment Assessment
☐ Cardiopulmonary Function Assessment (heart failure/dilated CMP)
☐ Other: _____

MEDICAL HISTORY

☐ no active medical conditions

ACTIVE MEDICATIONS

☐ no medications

DRUG ALLERGIES

☐ no known drug allergies

All test results will be reviewed in consultation with our cardiovascular specialists