MILTON CARDIAC IMAGING

2800 High Point Dr Unit 215
Milton, ON L9T 6P4
Tel: (905) 878-9805
Fax: (877) 927-8460

Patient Information:

Last Name: _____ First Name: _____ Date of Birth: _____

Health Card #: _____ Gender: _____

Address: _____ City: _____ Province: _____ Postal Code: _____

Telephone #: _____ Cell #: _____ Email: _____

Myocardial Perfusion Imaging

- □ Exercise
  - □ Continue all medications
  - □ HOLD Beta blocker for 48h prior to test

  _____
- □ Persantine
- □ Persantine with 2 min walk
- □ Rest Ventricular Function (MUGA)

Height: _____ **Weight:** _____

Clinical Indication:

Referring Provider:

Name of Referring Provider: _____ Billing #: _____ Date: _____
Address: _____ City: _____ Province: _____ Postal Code: _____
Phone #: _____ Fax #: _____

Signature: _____ Copies to: _____ Phone: _____ Fax: _____