SAULT AREA HOSPITAL
HÔPITAL DE SAULT-SAINTE-MARIE
iCare

DEMOGRAPHIC LABEL

Electrocardiograph (ECG) Requisition

Patient Name: ________________________________ D.O.B. ____________ Telephone: _________________

Address: ____

Health card number: _______________________

☐ Inpatient ________ ☐ Outpatient_________ ☐ ED _________

Exam required:

☐ 12 lead ECG
☐ 15 lead ECG

Comments:

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☐ Medical Directive

Date: ______________________ Signature: __________________________________

NOTE: This is a **CONTROLLED** document as are all files on this server. Any documents appearing in paper form are not controlled and should **ALWAYS** be checked against the server file versions (electronic version) prior to use

Health Records – Do Not Destroy