EKG Request Form

Patient Information:

- **Name:** _____
- **Date of Birth:** _____
- **Gender:** Male Female Other
- **Medical Record Number:** _____
- **Contact Number:** _____

Referring Physician Information:

- **Name:** _____
- **Specialty:** _____
- **Contact Number:** _____
- **Fax Number:** _____

Clinical Indication for EKG:

Routine Check
Chest Pain
Palpitations
Syncope
Shortness of Breath
Other: _____

Medications:

- **Current Medications:** _____
- **Allergies:** _____

Additional Notes:

_____

_____

Signature of Physician: _____

Date: _____

For Clinic Use Only:

- **Date of EKG:** _____
- **Technician's Name:** _____
- **Results Reviewed by:** _____
- **Date of Review:** _____

Instructions: Please complete this form and submit it along with the patient to the EKG department. Thank you!