ShaleDiagnostics

INSURED SERVICES REQUISITION

(Physician Referral Required)

PO Box 6717
Unit 3, 5004 50th Avenue
Drayton Valley, AB, T7A 1S1
Ph & Fax 780-898-4242
inquiries@shalediagnostics.ca
www.shalediagnostics.ca

LAST NAME	FIRST NAME	GENDER	DATE OF BIRTH

ADDRESS	CITY	POSTAL CODE

HOME PHONE	CELL PHONE	EMAIL

PERSONAL HEALTH CARE NUMBER	FAMILY DOCTOR

Audiogram and Tympanogram (5yrs+)

☐ **Audiogram** ☐ **Tympanogram** ☐ **Audiogram + Tympanogram**

Reason for testing, check all that apply:

☐ Suspected hearing loss? ☐ Sudden (Date:_____)
☐ Right ☐ Left ☐ Both

☐ Ringing in the ears?
☐ History of noise exposure?
☐ Has hearing aid(s)?
☐ History of tubes/Surgery? Date/Age:_____
☐ Recurrent Infections?

Electrocardiogram

☐ **ECG**

Reason for testing, check all that apply:

☐ Routine Health Assessment ☐ Palpitations
☐ Chest Pain ☐ Syncope
☐ Pre-Anesthetic ☐ Other Reason:_____

Respiratory (5yrs+)

☐ **Spirometry** ☐ **Vital Capacity Only** ☐ **Spirometry Pre + Post Bronchodilator**

Reason for testing, check all that apply:

☐ Routine\ Pre-Anesthetic ☐ Monitoring - Known Asthma
☐ Suspected Asthma ☐ Monitoring - Known COPD
☐ Suspected COPD ☐ Other Reason:_____

Vision

☐ **Colour Vision Test (Ishihara)**

Reason for testing, check all that apply:

☐ Routine Screening ☐ Vision Related Symptoms (visual strain, headaches)
☐ Suspected Colour Vision Deficiency ☐ Low light Visual Disturbance

Vascular

☐ **Ankle Brachial Index (ABI)**

Reason for testing, check all that apply:

☐ Diabetes ☐ History of Tobacco use
☐ Hypertension ☐ Known vasculopathy (prior MI/CVA etc)
☐ Hypercholesterolemia ☐ Suspected Peripheral Arterial Disease

Additional Information / Special Concerns / Comments

Ordering Provider

Physician Name		Clinic Stamp (optional)
Prac ID		
Address		
Phone		
Fax		