Tolman Clinical Laboratory
North Atlantic Medical Services
125 Tolman Avenue
Leominster, MA 01453

Fax Number: (888) 538-2221
Transmit: 1-800-453-6466
Client Service: 1-800-229-6267

Account Name:
Address:
Address:
Phone:
Fax:
NAMS Acct.#
Ordering Physician:_____

24-Hour Holter Monitoring Enrollment Form

Please complete ALL sections of this form

Patient Information **MR #** _____

Patient's Name: (Last Name)_____(First Name)_____(MI) ____

Address: ***(No PO Box)***_____(City)_____(State)_____(Zip)_____

Home Phone:_____Work Phone:_____Date of Birth:_____Sex:_____

Equipment must be returned immediately at the end of the monitoring period to the facility where you had the monitor applied. Timely return of the monitor will allow for prompt processing of the data pertaining to your health. I understand that if I fail to return the monitor or if damage occurs to the unit I will be financially responsible for the replacement cost.

Equipment Return Date:_____

_____Patient Signature (Parent if a Minor) Date_____

Fee for Service

Return this form with the diary

Start Date and Time: _____

Pt Setup/instructed by: _____

Holter Recorder Serial #: _____

Does pt have pacemaker: θYes θNo

Pacemaker Type:_____Parameters:_____

Cardiac Meds: _____

Diagnosis (Indicate one or more)

____Dizziness (780.4)
____Syncope and collapse or near syncope (780.2)
____Angina Pectoris (413.9)
____Post MI, early (410.9)
____Arrhythmia, unspecified (427.9)
____Premature beats (427.60)
____Afib (427.31)
____Aflutter (427.32)
____Paroxysmal SVT (427.0)
____Paroxysmal Vtach (427.1)
____Paroxysmal Tachycardia, unspecified (427.2)
____AV Block, Complete (426.0)
____2nd Degree AV Block (Mobitz Type II) (426.12)
____2nd Degree AV Block (Mobitz Type I) (426.13)

I certify that this test is medically necessary for the proper evaluation and treatment of this patient.

Physician Signature:_____Date:_____