GARANI CARDIAC CENTRE
OSAMA GARANI, MD, FRCPC, CARDIOLOGIST

Re: Home Holter Program

Dear Health Care Providers,

As the COVID-19 pandemic rapidly evolves we, at the Garani Cardiac Centre (GCC), aim to provide safe, timely and reliable cardiac monitoring services to meet the demand for remote home testing while encouraging social distancing by reducing the need for patients to leave the safety of their home.

The Home Holter Program is an innovative initiative allowing Health Care Providers to request at-home, contactless, patient monitoring through a simple referral form. Once submitted, the monitor will be mailed directly to the patient within 24-48 hours.

The miniHolter monitor is compact (16 gms), water-resistant and easy to use as the patient simply peels and places the patch. After 72 hours, the patient returns the monitor, via a prepaid envelope, to be read by our cardiologist.

We offer a 24/7 Patient helpline: 1-855-404-5667 where our certified cardiovascular technicians will address any patient concerns.

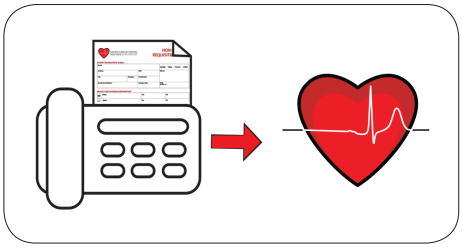
Sincerely,

Dr. Osama Garani
MD, FRCPC, Cardiologist

4056 Dorchester Road, Suite 200 • Niagara Falls, ON • L2E 6M9 • P: 905-228-9955 • F: 905-228-0990

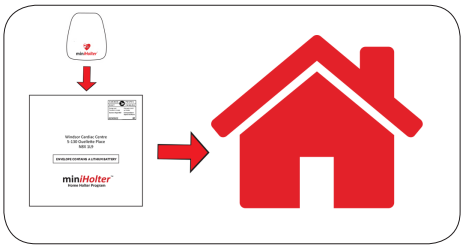
This program is easy to adopt and can be summarized in 5 simple steps:

1 Request



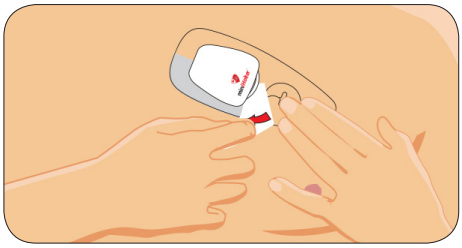
Health care provider requests Home Holter Monitor by faxing requisition to our Toll Free Line: 1-844-329-5667

2 Send



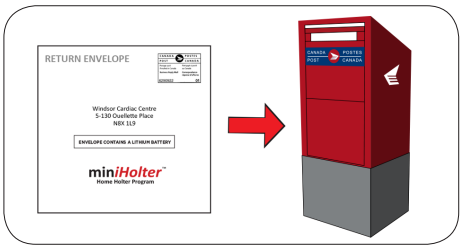
We mail a ready-to-use **min*iHolter*** to the patients home within 24-48 hours.

3 Peel & Attach



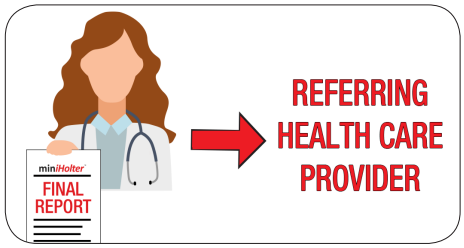
Patient will peel off the plastic backing and attach the patch to chest.

4 Return



After 72 hours, patient will remove the patch and return it to our monitoring centre via the prepaid, pre-addressed, envelope.

5 Analysis



Our certified technicians and reading specialists will analyze the data, finalize the findings and send the final report to referred physician.

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HOME HOLTER REQUISITION FORM

PATIENT INFORMATION (LABEL)

Name			Gender ☐ Male ☐ Female ☐ Other
Address		Unit	Home Phone
City	Province	Postal Code	Cell Phone
Health Card Number		Version Code	DOB (DD/MM/YYYY)

HEALTH CARE PROVIDER INFORMATION

Ref	Name	Fax	Tel
CC	Name	Fax	Tel

REASON FOR REFERRAL

- ☐ A-Fib / Flutter R/O
- ☐ Chest Pain
- ☐ Dizziness
- ☐ Lightheaded
- ☐ Palpitation
- ☐ Presyncope
- ☐ Syncope
- ☐ Rule out Bradycardia
- ☐ Rule out Cardiac Arrythmia
- ☐ Rule out PAF
- ☐ Rule out Tachycardia
- ☐ Shortness of Breath
- ☐ TIA / Stroke*

**N Engl J Med 2014; 370:2467-2477 June 26, 2014*

Other: _____

CURRENT MEDICATION(S)

- ☐ Antiarrhythmic
- ☐ Anticoagulant
- ☐ Antiplatelet
- ☐ ACE Inhibitor
- ☐ A-II Receptor Blocker
- ☐ ASA
- ☐ Beta-Blocker
- ☐ Ca Channel Blocker
- ☐ Digoxin
- ☐ Diuretic
- ☐ Nitrate
- ☐ Statin

Other: _____

DEVICE(S)

Does the patient have a Pacemaker or Implanted Cardiac Defibrillator?

- ☐ Pacemaker
- ☐ Defibrillator

☐ Please automatically schedule a phone consult if test is abnormal

Physician Signature _____ **Date** _____

Please Fax Requisition to: 1-844-329-5667

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