## T WAVE CHANGES

PRODUCER NAME:_____

CLIENT NAME: _____

Submit the Client Information Questionnaire with this form

1. How long has this abnormality been present?

2. Has there been any recent change in the ECG (last 12 month)?
   ☐ Yes; please give details _____
   ☐ No

3. Please check if your client has had any of the following:
   (check all that apply)

   a) chest pain, coronary artery disease,
   or other cardiovascular impairment ☐ yes ☐ no
   If yes, please give details _____
   b) diabetes ☐ yes ☐ no
   c) elevated cholesterol ☐ yes ☐ no
   d) high blood pressure ☐ yes ☐ no

4. Have any other studies been completed?
   a. exercise treadmill or thallium: ☐ no ☐ yes—normal ☐ yes—abnormal
   b. resting or exercise echocardiogram: ☐ no ☐ yes—normal ☐ yes—abnormal

5. Is client on any medications? (accurate name, dosage, and reason)

6. Does your client have any other major health problems? (additional questionnaires may be required)

Please fax to 612-392-7644 or email to mvp@mvpservicesolutions.com