ECHOCARDIOGRAPHY REQUISITION

To book a test, please FAX requisition to Central Scheduling at fax number: 1-855-702-1968

Prefered Site:
- ☐ Markdale
- ☐ Owen Sound
- ☐ Southampton

PATIENT IDENTIFICATION:

Legal Name on HC: *(last, first)*

DOB: *(yyyy-mmm-dd)* Gender:

Telephone: Alternate Telephone:

Health Card No: Version: Expiry:

City: Province: Postal Code:

PHYSICIAN IDENTIFICATION:

Referring Physician: Physician Number:

Referring Physician's Contact Info: *(address, telephone, fax)* CC Report to:

Patient Location: ❒ Home ❒ Inpatient/Hospital:______________________________

Is this a pre-operative assessment? ❒ Yes ❒ No Scheduled Surgical Date:

Has the patient previously been seen by a Cardiologist? ❒ Yes ❒ No ❒ Specify:

Has the patient had an Echo in the past 6 months? ❒ Yes ❒ No ❒ Date:

REQUEST: **❒ Transthoracic (TTE)** **❒ Transesophageal (TEE) *Owen Sound only**
❒ Bubble Study (Agitated Saline Study) * Owen Sound only **❒ Contrast* Owen Sound only**

PRIORITY: ❒ Urgent ❒ Routine ❒ Days ❒ Weeks

INDICATION: (Check all that apply) ***Requisitions without appropriate indication/clinical information will be returned to sender.***

❒ Prior MI	❒ Cardiac Cath	❒ CABG	❒ Valve Replacement
❒ Mechanical	❒ Tissue *Model:* ______________________		❒ Chest Pain
❒ Dyspnea	❒ Palpitations	❒ AFib	❒ Syncope
❒ Murmur: ______________________		❒ LV Dysfunction	❒ Cardiomyopathy
❒ Aortic Disease	❒ Source of embolus	❒ Pericardial Disease	❒ Chemotherapy
❒ LVH	❒ RV Dysfunction	❒ Congenital	❒ Pulmonary HTN
❒ Valve Disease: ______________________		❒ Smoker	❒ Diabetic
❒ Dyslipidaemia	❒ Hypertension	❒ Stroke/TIA	❒ PVD
❒ Family History CAD	❒ Abnormal ECG	❒ Other:	

Patient Weight: Patient Height:

CLINICAL INFORMATION:

Time/Date of Appointment:

Physician Signature: **Date of Request:**