

## ECHOCARDIOGRAPHY REQUISITION

### TRANSTHORACIC ECHOCARDIOGRAM

Registration/ Appointment Booking Office: 519-364-2340 ext 260

**To book a test, please FAX requisition to 519-364-0062**

<b>PATIENT IDENTIFICATION:</b>			
MRN/ID:	<input type="checkbox"/> Outpatient	<input type="checkbox"/> Inpatient	<input type="checkbox"/> Isolation
Legal Name on HC: <i>(last, first)</i>			
DOB: <i>(yyyy-mm-dd)</i>	Gender:		
Telephone:	Alternate Telephone:		
Health Card No:	Version:	Expiry:	
City:	Province:	Postal Code:	
<b>Priority:</b>	<input type="checkbox"/> Urgent	<input type="checkbox"/> Routine	<input type="checkbox"/> Days <input type="checkbox"/> Weeks
<b>PHYSICIAN IDENTIFICATION:</b>			
Referring Physician:		Physician Number:	
Referring Physician's Contact Info: <i>(address, telephone, fax)</i>		CC Report to:	
Patient Location: <input type="checkbox"/> Home <input type="checkbox"/> Hospital: _____			
Is this a pre-operative assessment? <input type="checkbox"/> Yes <input type="checkbox"/> No		Scheduled Surgical Date:	
Has the patient previously been seen by a Cardiologist? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, please specify:</i>			
Has the patient had an Echo in the past 6 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Date of last Echo:</i>			
<b>INDICATION:</b> (Check all that apply) <i>*Requisitions without appropriate indication/clinical information will be returned to sender.</i>			
<input type="checkbox"/> Prior MI	<input type="checkbox"/> Cardiac Cath	<input type="checkbox"/> CABG	<input type="checkbox"/> Valve Replacement
<input type="checkbox"/> Mechanical	<input type="checkbox"/> Tissue <i>Model:</i> _____		<input type="checkbox"/> Chest Pain
<input type="checkbox"/> Dyspnea	<input type="checkbox"/> Palpitations	<input type="checkbox"/> AFib	<input type="checkbox"/> Syncope
<input type="checkbox"/> Murmur: _____		<input type="checkbox"/> LV Dysfunction	<input type="checkbox"/> Cardiomyopathy
<input type="checkbox"/> Aortic Disease	<input type="checkbox"/> Source of embolus	<input type="checkbox"/> Pericardial Disease	<input type="checkbox"/> Chemotherapy
<input type="checkbox"/> LVH	<input type="checkbox"/> RV Dysfunction	<input type="checkbox"/> Congenital	<input type="checkbox"/> Pulmonary HTN
<input type="checkbox"/> Valve Disease: _____		<input type="checkbox"/> Smoker	<input type="checkbox"/> Diabetic
<input type="checkbox"/> Dyslipidemia	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Stroke/TIA	<input type="checkbox"/> PVD
<input type="checkbox"/> Family History CAD	<input type="checkbox"/> Abnormal ECG		
Patient Weight:		Patient Height:	
<b>CLINICAL INFORMATION:</b>			
<b>Office Use Only</b>	Date Requisition Received: _____		
	Scheduled Appointment Date and Time: _____		
	Patient Notified: <input type="checkbox"/>		
<b>Physician Signature:</b>		<b>Date of Request:</b>	