Date of Request: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

AH Patient Label

Last Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB:\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HC # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Version Code\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

M F **APPOINTMENT DATE**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **TIME**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

OUTPATIENT INPATIENT/E-ORDER E EMERG PT/E-ORDER RESTRICTED MOBILITY

**APPOINTMENT DETAILS: Please arrive 15 minutes early and report to Patient Registration. Bring this requisition and your Health Card to this appointment. Patients with no requisition will be re-scheduled. Late arrivals may require re-scheduling. If unable to keep this appointment, contact Registration at 519-485-9611.**

|  |  |  |  |
| --- | --- | --- | --- |
| **IDENTIFY ALL PERTINENT CLINICAL INFORMATION & PATIENT HISTORY (Check all that apply)**   **STANDARD INDICATIONS FOR ECHOCARDIOGRAPHY** | | | |
|  | Pre-op Assessment:Date of Surgery \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | Aortic Aneurysm-Known or Suspected |
|  | Pre/Post Cardiac Surgery:Please specify\_\_\_\_\_\_\_\_\_\_ |  | Cardiomyopathy-Known or Suspected |
|  | Pre/Post Chemotherapy/Radiation Therapy |  | Cardiac Masses |
|  | Pre-Cardioversion/ Pre-Pacemaker/ICD |  | Edema |
|  | Post Ablation or pacemaker implant |  | Infective Endocarditis-Known or Suspected |
|  | Pre/post Interventional Procedures including angioplasty |  | Mitral Valve Prolapse (MVP)-Known or Suspected |
|  | Abnormal Chest x-ray |  | Myocardial Infarction- Known or Suspected |
|  | Abnormal ECG/EKG \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | Myocarditis-Suspected |
|  | Angina/Chest Pain/Tightness |  | Palpitations /Arrhythmias |
|  | Coronary Artery Disease (CAD) |  | Pericardial Effusion-Follow up or Suspected |
|  | Congestive Heart Failure (CHF) |  | Pericardial Disease-Known or Suspected |
|  | Dyspnea (SOB) |  | Pulmonary Diseases: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | Heart Disease-Known or Family History (Genetic) |  | Pulmonary Embolism- Known or Suspected |
|  | Heart Disease-Suspected or Structural |  | Thoracic Aortic Disease |
|  | Heart Murmur Grade: \_\_\_\_/6 Sys Dia |  | Valvular Regurgitation |
|  | Hypertension |  | Valvular Stenosis |
|  | Syncope/Pre-Syncope |  |  |
|  | Prosthetic Heart Valves-Year **\_\_\_\_\_\_\_\_\_\_**  Aortic Mitral Tricuspid Pulmonic |  | Neurologic or Other Possible Embolic Events  **Suspected Clot/Thrombus** (Stroke/TIA):\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | Congenital or Inherited Cardiac Structural Disease (ASD, VSD, Bicuspid AoV, Marfan’s Syndrome or \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | **Other Clinical Indication and additional information:** |

**Patient Height: \_\_\_\_\_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_\_\_\_\_ (WEIGHT LIMIT 350 LBS/159 KG)**

Medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Ordering Physician:** (Print name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Copy to\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Office Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Copies to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: YYYY/MM/DD \_\_\_\_\_\_\_\_\_\_\_\_\_\_ REV 02/2018