



**ALEXANDRA MARINE & GENERAL HOSPITAL**  
 120 Napier Street, Goderich, Ontario N7A 1W5  
 Phone (519) 524 8323; Fax (519) 524 8532

Office Use Only

Patient Health Record #: \_\_\_\_\_

Appointment Date and Time: \_\_\_\_\_

**CARDIORESPIRATORY: ECHOCARDIOGRAM REQUISITION**

**Please fax completed requisition to 519-524-8532**

**PATIENT INFORMATION: (please print or affix label)**

\_\_\_\_\_  
 Patient Last Name

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

\_\_\_\_\_  
 Health #

\_\_\_\_\_  
 Version

\_\_\_\_\_  
 Expiry (Year/Month)

\_\_\_\_\_  
 D.O.B. (Year/Month/Day)

Gender:  Male  Female

\_\_\_\_\_  
 Phone Number

**ECHO INDICATIONS: (check boxes below)**

- Chest pain
- Palpitations
- SOB
- HTN
- Presyncope/ Syncope
- TIA/Stroke
- Arrythmia
- Murmur
- Dyspnea (OE?)
- Cardiomyopathy

- CHF(with/without Edema)
- Valvular Stenosis of: \_\_\_\_\_
- Valvular Regurgitation of: \_\_\_\_\_
- Mitral Valve Prolapse
- Congenital Defect
- Prosthetic Heart Valve
- Endocarditis
- Abnormal CXR
- Abnormal ECG
- Other? (explain) \_\_\_\_\_

**MEDICATIONS:**

**QUESTIONS YOU NEED ANSWERED BY THIS EXAM:**

**REFERRING PHYSICIAN:**

Practitioner's Name (Print) \_\_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_ Postal Code: \_\_\_\_\_ Tel: \_\_\_\_\_ FAX: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_ Billing No: \_\_\_\_\_

Copy to: \_\_\_\_\_ Date: \_\_\_\_\_  
 (dd/mm/yyyy)