

Office Use Only

Appointment Date and Time: _____

Patient Health Record #: _____

CARDIORESPIRATORY: ECHOCARDIOGRAM REQUISITION

Please fax completed requisition to 519-524-8532

Note: We do not do Echocardiograms on patients under the age of 18 years old

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
- ☐ Arrhythmia
- ☐ 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 PRACTITIONER:

Practitioner's Name (Print) _____ Address: _____

City: _____ Postal Code: _____ Tel: _____ FAX: _____

Practitioner's Signature: _____ Billing No: _____ CPSO/CNO/Reg. No: _____

 Copy to: _____ Date: _____
 (dd/mm/yyyy)