ECHOCARDIOGRAPHY REQUISITION

Timmins & District Hospital

Diagnostic Imaging / Ultrasound Department

Tel: 705-267-2131 ext 2051 **Fax**: 705-267-6346

Name:		**Date of Birth**		
Address:	**Age:** (16years+)	**Day**	**Month**	**Year**
	Sex:			
Postal Code:	**Health Card:**			
Telephone Home Number:	**Cell:**	**Work:**		
Height cm:	**Weight kg:**			
Pacemaker? Y / N	**Defibrillator patient?** Y / N			
Reason for Request:				

☐ **Chest Pain**	☐ **Post PCI /CABG**	☐ **Dyspnea**
☐ **History of MI**	☐ **Palpitations**	☐ **Stroke / TIA**
☐ **Arrhythmia**	☐ **Heart Function/Failure**	☐ **Syncope**
☐ **Murmur / Valve Disease**		
☐ **Other Pertinent Clinical Information:**		**CONTRAST** ☐ **Definity** **Lot:**_____ **Exp:** _____

Previous Echo: Y / N	**Date:**
Allergies: Y / N	**List:**
Referring Physician:	**Billing Number:**
Signature of Referring Physician:	**Date:**
Copy of Report to Family Physician:	**Copy to Other Physician:**

Date Received:	**Date of Appointment:**
	Time: