



Echocardiogram Requisition

Timmins & District Hospital

Diagnostic Imaging / Ultrasound Department

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Patient Name:		Date of Birth		
Patient Address:		Age: (16years+)	Day	Month
		Sex:		Year
Patient Phone Number:		Health Card #:		
Patient Height:	Patient Weight:	Allergies? <input type="checkbox"/> No <input type="checkbox"/> Yes:		

Clinical Indicators (check all that apply):	
<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Pulmonary Disease
<input type="checkbox"/> Prosthetic Heart Valve	<input type="checkbox"/> Before Cardioversion
<input type="checkbox"/> Cardiac Mass	<input type="checkbox"/> Native Valvular Regulation
<input type="checkbox"/> Interventional Procedure (if yes, what?)	<input type="checkbox"/> Pericardial Disease
<input type="checkbox"/> Thoracic Aorta Disease	<input type="checkbox"/> Known or Suspected Mitral Valve Prolapse
<input type="checkbox"/> Arrhythmias/Syncope/Palpitations	<input type="checkbox"/> Chest Pain / CAD
<input type="checkbox"/> Dyspnea/Edema/Cardiomyopathy	<input type="checkbox"/> Neurologic/Embolic Event/CVA
<input type="checkbox"/> Native Valvular Stenosis	<input type="checkbox"/> Suspected Structural Heart Disease
<input type="checkbox"/> Infective Endocarditis	<input type="checkbox"/> Congenital/Inherited Cardiac Structural Disease
<input type="checkbox"/> Hypertension	<input type="checkbox"/> Other:

Other Pertinent Clinical Information (if applicable):	
Previous Echo: <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, date of previous echo:
Referring Physician:	Billing Number:
Signature of Referring Physician:	Date:
Copy of Report to Family Physician:	CC to Other Physician:

For TDH Technologist and Schedulers:	
Date Received:	Date of Appointment:
	Time: