CAMPBELLFORD MEMORIAL HOSPITAL 1.1

Echocardiogram Requisition

Fax requisition to the Booking Department 705-653-3601

Testing	☐ Routine ☐ Urgent	☐ Outpatient ☐ Inpatient

Patient Demographics/Label		Date:
Last Name:		**Medications**
First Name:	Sex: ☐ M ☐ F	Is patient on CCB or BB? ☐ Yes ☐ No
Address:		Medications:
City:	Postal Code:	
Phone Number:		**MD INFO**
DOB:	Age:	Referring MD:
HCN:		Billing #:
		Signature:
Height:_____in/cm		CC:
Weight:_____lb/kg		GP:

History:

Clinical Information: ***MANDATORY***

- ☐ CHF
- ☐ LVH
- ☐ LV Systolic Function
- ☐ LV Diastolic Function
- ☐ PA Pressure
- ☐ Post PTCA/CABG
- ☐ Dyspnea
- ☐ Pre-Op
- ☐ Murmur, NYD
- ☐ Aortic Stenosis
- ☐ Aortic Regurgitation
- ☐ Mitral Stenosis
- ☐ Mitral Regurgitation
- ☐ HTN
- ☐ Syncope
- ☐ Tricuspid Regurgitation
- ☐ Pericardial Effusion
- ☐ Source of Embolism
- ☐ Congenital Heart Disease
- ☐ Palpitations
- ☐ Chest pain

☐ Mechanical valve ☐ AV ☐ MV

☐ Bioprosthetic Valve ☐ TV ☐ PV

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**Appointments will not be booked until a completed requisition is received. Incomplete requisitions will be returned.*

Revised Oct.2015