Echocardiogram Requisition

Fax requisition to the Booking Department 705-653-3601

CAMPBELLFORD MEMORIAL HOSPITAL

Testing	☐ Inpatient	☐ Outpatient

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:		Referring MD: Billing #:
HCN:		Phone #: Fax #:
		Signature:
Height:	☐ **in/cm** ☐	CC:
Weight:	☐ **lb/kg** ☐	GP:

****MANDATORY****

History:

PATIENT HISTORY/TEST INDICATION: Please indicate if any of the following exist. ****MANDATORY****

- ☐ LBBB
- ☐ Afib
- ☐ CAD/MI
- ☐ PTCA/CABG
- ☐ Palpitations
- ☐ TIA/CVA
- ☐ Diabetes
- ☐ Moderate/Severe Asthma
- ☐ Hypertrophic Cardiomyopathy
- ☐ Murmur (NYD)
- ☐ > 10% on Framingham Risk Score
- ☐ Chest Pain
- ☐ Pericardial Effusion
- ☐ Shortness of Breath
- ☐ Mitral Regurgitation
- ☐ Mitral Stenosis
- ☐ Aortic Regurgitation
- ☐ Aortic Stenosis
- ☐ Tricuspid Regurgitation
- ☐ Pacemaker
  - ☐ Single Chamber
  - ☐ Dual Chamber
  - ☐ ICD
- ☐ Valve Disease
- ☐ Congenital Heart Disease
- ☐ Congestive Heart Failure
- ☐ Hypertension
- ☐ Valve Replacement:
  - ☐ Mechanical
  - ☐ Tissue
  - ☐ Aortic Valve
  - ☐ Mitral Valve

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