Brightshores Health System	**Echocardiography Requisition**	**Number:**	**ECF001**
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Category:	Cardiology	**Issued by:**	MIC Quality Manager

Fax completed requisition to Scheduling at: 1-855-702-1968	**Preferred Site:** ☐ Owen Sound ☐ Markdale ☐ Southampton

Request: ☐ Transthoracic (TTE) ☐ Transesophageal (TEE) **Owen Sound only*

Patient Name:_____ Address:_____

Date of Birth:_____ Postal Code:_____

HCN:_____ Telephone:_____

Weight:_____ Height:_____ Gender:_____ Alt. Phone:_____

☐ Outpatient ☐ Hospital Inpatient: _____ ☐ Isolation

Priority: ☐ Urgent ☐ Routine _____Days_____Weeks

Is this a pre-operative assessment? ☐ Yes ☐ No Date of Scheduled Surgery: _____

Has the patient been seen by a Cardiologist? ☐ Yes ☐ No Specify: _____

Has the patient had an Echo in past 6 months? ☐ Yes ☐ No Date: _____

Indication: (check all that apply)

Requisitions without appropriate indication/clinical information will be returned to sender.

☐ Prior MI ☐ Cardiac Cath ☐ CABG ☐ Chest Pain

☐ Valve Disease:_____

☐ Murmur: _____ ☐ LV Dysfunction ☐ Cardiomyopathy

☐ Valve Replacement – Model: ☐ Mechanical_____ ☐ Tissue_____

☐ Dyspnea	☐ Palpitations	☐ AFib	☐ Syncope
☐ Aortic Disease	☐ Source of embolus	☐ Pericardial Disease	☐ Chemotherapy
☐ LVH	☐ RV Dysfunction	☐ Congenital	☐ Pulmonary HTN
☐ Stroke/TIA	☐ PVD	☐ Dyslipidemia	☐ Hypertension
☐ Family History CAD	☐ Abnormal ECG	☐ Diabetic	☐ Smoker

Clinical Information:

Referring Physician Information:

Name: Telephone:

Physician Billing #: Fax:

Signature: Date of Referral:

CC Report to:

Office Use Only:

Date Req Received: _____ Time/Date of Appointment:_____

☐ Patient Notified ☐ Tech Initials _____ Date _____