DIAGNOSTIC IMAGING – ECHOCARDIOGRAM

Huntsville District Memorial Hospital
100 Frank Miller Drive
Huntsville, ON, P1H 1H7
T: 705-789-2311 x2242
F: 705-788-1485

South Muskoka Memorial Hospital
75 Ann Street
Bracebridge, ON, P1L 2E4
T: 705-645-4404 x3112
F: 705-645-7567

PATIENT BOOKING LINE: 1-877-348-6264

Patient Demographics:

Name Last First

Address

Home Phone ( ) - Other Phone ( ) -

☐ **Do not contact patient.** Provide appointment date/time to referring provider.

DOB YYYY / MM / DD ☐ Male ☐ Female

OHIP

Isolation Precautions: ☐ Contact ☐ Droplet/Contact ☐ Airborne

Special Instructions (mobility, communication, etc.): _____ ☐ Falls Risk ☐ Wheelchair req'd

Priority: ☐ Less than 2 weeks ☐ Urgent Outpatient (<48 hrs)

Echocardiogram History:

☐ Transthoracic Echocardiogram ☐ With agitated saline (<55 years of age to r/o source of emboli)

Previous Echocardiogram: ☐ Yes ☐ No Date and location of last Echo:

*Please attach a copy of previous echo from other locations with this requisition

Please note: Contrast echocardiogram and Transesophageal echocardiogram requests are to be sent to RVH.

Indication for Study/Relevant Clinical History:

- ☐ R/O Cardiac source of emboli
- ☐ CHF
- ☐ Known CAD
- ☐ Hypertension
- ☐ Endocarditis
- ☐ Murmur
- ☐ Chest Pain
- ☐ Prosthetic heart valve (type/card)
- ☐ Cardiomyopathy
- ☐ R/O Effusion/ Tamponade
- ☐ Pre Pacemaker
- ☐ Atrial Fibrillation
- ☐ RVH Oncology
- ☐ Presyncope/Syncope

CorHealth indication number:_____

(Please refer to the CCN Standards of Echocardiography in Ontario 2015 or http://www.ccnecho.ca/UploadedFiles/files/CCN_Echo_Standards_2015.pdf

Referring Provider:	Signature:
Copies to:	OHIP Billing #:

These examinations must be booked; please fax to our office.

Incomplete:

- ☐ Patient Information
- ☐ Exam Requested
- ☐ Printed name/CPSO
- ☐ Clinical History
- ☐ Signature

Refaxed to office _____

Office use only: *VERSION: June 2019*