



REV July 31, 2012 7102-2726-0



ADULT CARDIOLOGY PROGRAM ECHOCARDIOGRAPHY REQUEST

STUDY REQUESTED:				
☐ Transthoracic Echocardiography (TTE)	☐ Saline Contrast ("Bu	ubble") Study		
The state of the s			/ Approval by Cardiologist	
☐ Transesophageal Echocardiography (TEE)	☐ Pericardiocentesis	☐ Stress TTE	- Exercise	
Paguaget Data	1 1	Patient Name:		
Request Date:///////			First Last	
Referring Physician:	Last	Address:	Destal Onder	
		1	Prov.: Postal Code:	
Patient location? Home Hospital		Cell: ()	Work: ()	
Hospital Name: Ward:		DOB. /		
Ward Phone: Ward Fax:			_/ Gender: ☐ Male ☐ Female	
Translator required: ☐ Yes ☐ No If yes, language?:		l	PHIN #:	
		Other #:	Type:	
PATIENT INFORMATION (please PRINT and/or	CIRCLE or CHECK)			
Height: (cm) Weight:				
Previous Echo? ☐ Yes ☐ No If yes, date: _	Location	on: SBG	H 🗆 Other	
Reason for This Study: New Clinical Problem				
CLINICAL HISTORY / STUDY QUESTION - Please			vailable.	
Congestive Heart Failure (CHF)	Endocarditis		Murmur	
Radiographic Confirmation	☐ + ve blood cultures (Bug)		☐ Associated cardiac symptoms	
☐ Clinical CHF	☐ Intermediate to high clinical likelihood		Asymptomatic	
Other (Specify):	(eg. Duke Score) Other (Specify):		Other (Specify):	
	Cirlei (Specify).		Ascending Aorta or Aortic Root	
Left Ventricular (LV) Function			☐ STRONGLY suspected	
Large MI Pericardial Effusion			☐ Follow-up of documented ascending aorta	
Rule out apical thrombus with recent anterior MI	☐ Strongly suspected ☐ Follow-up of known effusion ☐ Other (Specify):		or root aneurysm (Prior size) Other (Specify):	
Other (Specify):				
	() //		Congenital Heart Disease	
Valve Disease (including Prosthesis) Source of Embolism			☐ Must provide details:	
Prosthetic Valve (List size / type & date inserted):	☐ Confirmed associated			
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☐ Known valve disease	Other (Specify):		Other Indications (details):	
Other (Specify):	Pulmonary Artery (PA	\\ Pressure		
Rule out Structural Heart Disease		I		
☐ Signs or symptoms of heart disease	☐ Suspected / unknown	pulmonary hypertension		
☐ Documented significant arrhythmia	Other (Specify):			
Other (Specify):				
C	UTPATIENT REFERR	ALS FAX (204) 787-1	840	
ST. BONIFACE - BERGEN CARDIAC (` '	ALTH SCIENCES CENTRE SITE	
2 ND Floor, Y2		Rm GH720		
Appt. #: 204.235.3805 Fax #: 204.231.5727		Appt. #: 204.787.7140 Fax #: 204.787.1840		
Physician SIGNATURE:		Staff MD Name:		
		_		
	Fax #			
			Fax #	
FOR ECHO USE ONLY		I dA #		
□ NESS entry Categor		<u> </u>	Priority:	
☐ Appointment made ☐ A - F	Fit and ready 🔲 B - Del	ay due to medical	C - Delay due to personal choice ☐ 1 ☐ 2 ☐	