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Phone:



ALEXANDRA MARINE & GENERAL HOSPITAL

Napier Street, Goderich, Ontario N7A 1W5

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CARDIORESPIRATORY: ECHOCARDIOGRAM REQUISITION

Appointment Date: _____ **Time:** _____
(Month/Day/Year)

PATIENT INFORMATION: (please print or affix label)

Patient Last Name

First Name

Health #

Version

Expiry (Year/Month)

D.O.B. (Year/Month/Day)

Gender: Male Female

Phone Number

ECHO INDICATIONS: (check boxes below)

- Chest pain
- Palpitations
- SOB
- HTN
- Presyncope/ Syncope
- TIA/Stroke
- Arrhythmia
- Murmur
- Dyspnea (OE?)
- Cardiomyopathy

- CHF(with/without Edema)
- Valvular Stenosis of: _____
- Valvular Regurgitation of: _____
- Mitral Valve Prolapse
- Congenital Defect
- Prosthetic Heart Valve
- Endocarditis
- Abnormal CXR
- Abnormal ECG
- Other? (explain)_____

MEDICATIONS:

QUESTIONS YOU NEED ANSWERED BY THIS EXAM:

Referral Physician (Print Name)

Signature:

Copy to: (Print Full Name)

Date: (Month/Day/Year)

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