

**Patient Information:**

Name (Last, First): _____

Date of Birth (DOB): _____ ☐ Male ☐ Female
YYYY MM DD

Personal Identification Number (PIN): _____

Address: _____

Phone Number (Home): _____

(Other): _____

Health Card Number: _____ Version Code: _____

☐ Workplace Safety & Insurance Board (WSIB)? (Please include approval for specific exam)

Claim #: _____

Date of injury (YYYY/MM/DD): _____

3rd Party or Insurance (Company or Self-pay): _____

Patient Weight: **Kilograms (kg)**

(YYYY/MM/DD)

STANDARD INDICATIONS FOR ECHOCARDIOGRAM

	Abnormal Diagnostic Imaging Findings		Myocardial Infarction: Date (YYYY/MM/DD): _____	
	Arrhythmias/ Palpitations		Myocarditis	
	Cardiac Masses		Neurologic or Other Possible Embolic events	
	Cardiomyopathy: Describe		Pericardial Diseases: Describe	
	Chemotherapy/Cardio Toxic Drugs		Pre-Cardioversion/Pre-Pacemaker	
	Chest Pain or Tightness		Pre-Transplant Assessment	
	Coronary Artery Disease (previously diagnosed); if asymptomatic – 1 year follow-up		Prosthetic Heart Valve: Year _____ Aortic Mitral Tricuspid Pulmonic	
	Dyspnea (Shortness of Breath) or Edema		Pulmonary disease or Embolism: Describe:	
	Endocarditis		Suspected Structural Heart Disease: (with no previous echocardiogram)	
	Family History of Structural Cardiac Disease (Complex congenital anomalies refer to tertiary site)		Syncope / Pre-Syncope	
	Heart Failure		Thoracic Aortic Disease: Describe	
	Heart Murmur		Valvular Regurgitation: Aortic Mitral	Tricuspid Pulmonic
	Hypertension (new onset or uncontrolled)		Valvular Stenosis: Aortic Mitral	Tricuspid Pulmonic

History/Other: (May require approval)

UNSIGNED, INCOMPLETE REQUISITIONS WILL BE RETURNED AND APPOINTMENTS WILL NOT BE BOOKED UNTIL A SIGNED AND COMPLETED REQUISITION IS RECEIVED.