WINDSOR REGIONAL HOSPITAL
OUTSTANDING CARE – NO EXCEPTIONS!

ECHOCARDIOGRAPHY REQUISITION

Fax Requests to: (519) 255-2125
Contact for Questions: (519) 254-1727

INCOMPLETE / ILLEGIBLE REQUESTS WILL BE RETURNED - Resulting in delay of appointment booking

Patient Information (Please Print)

Name: _____ Date of Birth (mm/dd/yyyy): _____ Sex: ☐ M ☐ F

Address: _____ WSIB: _____ Weight: _____ lbs _____ Kg

Primary Contact # (___) _____ Secondary # (___) _____ Height: _____ ft _____ in

Health Card #: _____ Version _____ Patient arriving from ext. healthcare facility: ☐ Y ☐ N

☐ ECHO ☐ PAEDIATRIC ECHO (MET CAMPUS ONLY)

*****Paediatric Echo can only be referred by a Pediatrician*****

- ☐ Arrythmia / Palpitations
- ☐ CAD
- ☐ Cardiac Mass
- ☐ Cardiomyopathy / Dyspnea / Edema
- ☐ Chest pain / Coronary Artery Disease
- ☐ Congenital Cardiac Structural Disease
- ☐ Endocarditis
- ☐ Heart Murmur
- ☐ Hypertension
- ☐ Neuro/Embolic Events
- ☐ Pericardial Disease
- ☐ Prosthetic Heart Valve
- ☐ Pulmonary Disease
- ☐ Thoracic Aortic Disease
- ☐ Valvular Heart Disease
- ☐ Valvular Regurgitation
- ☐ Valvular Stenosis
- ☐ Other _____

Clinical Comments: _____

☐ TEE

Please ensure patient does not have history of esophageal injury/disease, esophageal varices, prior cervical spine surgery, ongoing GI bleeding or active peptic ulcer disease.

- ☐ Cardiac Source of Embolus
- ☐ Endocarditis
- ☐ Valvular Heart Disease
- ☐ Intracardiac Mass
- ☐ Atrial Septal Defect/Patent Foramen Ovale
- ☐ Other _____

Clinical Comments: _____

☐ Please attach previous Echo if done at outside Facility
☐ List Current Medications: _____

Referring Physician Information & Signature

Name (Print): Fax #:

Copy to (Drs):

Signature: Date (mm/dd/yyyy):

APPOINTMENT:

DATE (mm/dd/yyyy):_____ **TIME:** _____ **CAMPUS:** _____