WINDSOR REGIONAL HOSPITAL
OUTSTANDING CARE – NO EXCEPTIONS!

# ECHOCARDIOGRAPHY REQUISITION

**Fax Requests to:**
**Phone: (519) 254-1727 Fax: (519) 255-2125**

**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: ______________ Patient's Weight: ______ lbs ______ Kgs

Primary Contact # ( ) ____________ Secondary # ( ) ____________ Patient's Height: ______ ft ______ in

Health Card #: ______________ Version ________ Patient arriving from external healthcare facility: ☐ Y ☐ N

## ☐ ECHO ☐ PEDIATRIC ECHO - (MET CAMPUS ONLY)

☐ 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 Senosis
☐ Other ______________________

Clinical Comments:
______________________________________________
______________________________________________
______________________________________________
______________________________________________

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

## ☐ TEE ☐ TEE & Consult (OUELLETTE CAMPUS ONLY)

☐ 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______________________________________________
______________________________________________
______________________________________________
______________________________________________

Print Referring Physician ______________________ Fax Number ______________________

Copy to (Drs):______________________________________________

Referring Physician Signature:______________________________________________

**APPOINTMENT:**

**DATE (MM/DD/YYYY):______________ TIME: __________ CAMPUS: ______________**