Huron Health System
ALEXANDRA MARINE & GENERAL HOSPITAL
120 Napier Street, Goderich, Ontario N7A 1W5: Phone (519) 524 8323

CARDIORESPIRATORY: ECHOCARDIOGRAM REQUISITION
Please fax completed requisition to 519-524-8532

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
- ❑ Arrythmia
- ❑ 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) _____

Physician Billing # _____ **Date** (Month/Day/Year) _____