

Place Patient Label Here

# Echocardiogram Requisition

Telephone: 905-883-2004 Fax: 905-883-0772

Patient's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ (dd/mm/yyyy)

Health Card Number: \_\_\_\_\_

Telephone: \_\_\_\_\_ Can we leave a voicemail?  Yes  NoAdditional Reports To: \_\_\_\_\_ Date: \_\_\_\_\_  
dd/mm/yyyy

Referring Doctor's Name: \_\_\_\_\_

Signature: \_\_\_\_\_

**IMPORTANT APPOINTMENT  
INFORMATION:****Patient to arrive 20 mins prior to  
appointment, unless otherwise specified  
by the scheduler.****Patient to check in using our self-serve  
kiosks location in Patient Registration.****Echocardiography Indications:**

- Heart Murmur
- Known/ Suspected Valvular Stenosis
- Known/ Suspected Valvular Regurgitation
- Known/ suspected Mitral Valve Prolapse
- Congenital or Inherited Cardiac Structural Disease
- Prosthetic Heart Valve
- Infective Endocarditis
- Pericardial Disease
- Cardiac Masses
- Interventional Procedure
- Pulmonary Disease
- Chest Pain and Coronary Artery Disease
- Dyspnea, Edema and Cardiomyopathy
- Hypertension
- Thoracic Aortic Disease
- Neurologic or Other Possible Embolic Events
- Arrhythmias, Syncope and Palpitations
- Suspected Structural Heart Disease
- Initial and Periodic Assessment of LV function With Use of Cardiotoxic Drugs
- ECG Changes
- Transplant Work Up
- Others (please specify): \_\_\_\_\_

**Relevant Clinical Information:** *(must be provided and please be specific)*

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**Echocardiogram Type:**

- Transthoracic Echo (TTE)
- Limited Echo + Bubble Study (to rule out Cardiac shunt)



3062

(May 2024)