Winnipeg Regional Health Authority / Office régional de la santé de Winnipeg
Caring for Health / *À l'écoute de notre santé*

Hôpital St-Boniface Hospital

Health Sciences Centre Winnipeg

ADULT CARDIOLOGY PROGRAM

ECHOCARDIOGRAPHY REQUEST

Patient Name: _____ (First) _____ (Last)

Address: _____

City _____ Prov.: _____ Postal Code: _____

Home Phone: ( ) _____ Work / Cell: ( ) _____

D.O.B.: _____ (DD) / _____ (MM) / _____ (YYYY) Gender: ☐ Male ☐ Female

MHSC #: _____ PHIN #: _____

Other #: _____ Type: _____

Request Date: _____ (DD) / _____ (MM) / _____ (YYYY)

Referring Physician: _____ (First) _____ (Last)

Patient location? ☐ Home ☐ Hospital

Hospital Name: _____ Ward: _____

Ward Phone: _____ Ward Fax: _____

Translator required: ☐ Yes ☐ No If yes, language?: _____

ST. BONIFACE - BERGEN CARDIAC CARE CENTRE	HEALTH SCIENCES CENTRE SITE
2ND Floor, Y2	Rm GD 157 - Blue Desk
Appt. #: **235-3805** Fax #: **231-5727**	Appt. #: **787-7140** Fax #: **787-1840**

ALL REQUESTS MUST BE FORWARDED TO CORRECT LOCATION

PATIENT INFORMATION (please PRINT and/or CIRCLE or CHECK)

Height: _____ (cm) Weight: _____(kg) Allergies? _____

Cancer suspected? ☐ Yes ☐ No Is patient on chemotherapy ☐ Yes ☐ No

Preoperative Study ☐ Yes ☐ No If yes, date? _____ Pregnant patient? ☐ Yes ☐ No If yes, due date: _____

Patient travelling > 100km to attend a concomitant clinic appointment? ☐ Yes ☐ No If yes, date?_____

Previous Echo? ☐ Yes ☐ No If yes, date: _____ Location: ☐ HSC ☐ SBGH ☐ Other_____

Reason for This Study: ☐ New Clinical Problem ☐ Follow-up Details:_____

STUDY REQUESTED:

☐ Transthoracic Echocardiography (TTE) ☐ Saline Contrast ("Bubble") Study

TEE, Stress Echo or Pericardiocentesis ONLY with Prior Consultation / Approval by Cardiologist

☐ Transesophageal Echocardiography (TEE) ☐ Pericardiocentesis ☐ Stress TTE - Exercise ☐ Stress TTE - Pharmacologic

CLINICAL HISTORY / STUDY QUESTION - Please mark all that apply and add specific details if available.

Congestive Heart Failure (CHF)
- ☐ Radiographic Confirmation
- ☐ Elevated BNP
- ☐ Clinical
- ☐ Other (Specify): _____

Left Ventricular (LV) Function
- ☐ Shortness of Breath (SOB)
- ☐ Large MI by ECG or CK _____
- ☐ Rule out apical thrombus with recent anterior MI
- ☐ Other (Specify): _____

Valve Disease (including Prosthesis)
- ☐ Prosthetic Valve (List size / type & date inserted): _____
- ☐ Known valve disease_____
- ☐ Other (Specify): _____

Rule out Structural Heart Disease
- ☐ Signs or symptoms of heart disease
- ☐ Documented significant arrhythmia
- ☐ Other (Specify):_____

Endocarditis
- ☐ + ve blood cultures (Bug _____)
- ☐ Intermediate to high clinical likelihood (eg. Duke Score)
- ☐ Other (Specify): _____

Pericardial Effusion
- ☐ Strongly suspected
- ☐ Follow-up of known effusion
- ☐ Other (Specify): _____

Source of Embolism
- ☐ Confirmed associated heart disease
- ☐ Known atrial fibrillation
- ☐ Other (Specify): _____

Murmur
- ☐ Associated cardiac symptoms
- ☐ Other eg murmur NYD
- ☐ Type (systolic/diastolic) & grade_____
- ☐ Other (Specify): _____

Pulmonary Artery (PA) Pressure
- ☐ Known pulmonary hypertension
- ☐ Other (Specify): _____

Ascending Aorta or Aortic Root
- ☐ STRONGLY suspected
- ☐ Follow-up of documented ascending aorta or root aneurysm (Prior size _____)
- ☐ Other (Specify): _____

Congenital Heart Disease
- ☐ Must provide details: _____

Other Indications (details):

Physician SIGNATURE: _____ Staff MD Name: _____

SEND REPORT TO: (PLEASE PRINT)

Name:_____

Address: _____

Telephone #: _____ **Fax #** _____

Additional reports to:_____ **Fax #** _____

FOR ECHO USE ONLY

Category:
☐ **A** - Fit and ready ☐ **B** - Delay due to medical ☐ **C** - Delay due to personal choice

Priority:
☐ Emergent ☐ Urgent ☐ Elective

REV November 30, 2009 7102-2726-0