



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.: ____ / ____ / ____ Gender: Male Female
DD MM YYYY

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
2 ND Floor, Y2	Rm GH720
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): _____

Endocarditis

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

Pulmonary Artery (PA) Pressure

Known pulmonary hypertension
 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): _____

Pericardial Effusion

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

Ascending Aorta or Aortic Root

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

Valve Disease (including Prosthesis)

Prosthetic Valve (List size / type & date inserted): _____
 Known valve disease
 Other (Specify): _____

Source of Embolism

Confirmed associated heart disease
 Known atrial fibrillation
 Other (Specify): _____

Congenital Heart Disease

Must provide details: _____

Rule out Structural Heart Disease

Signs or symptoms of heart disease
 Documented significant arrhythmia
 Other (Specify): _____

Murmur

Associated cardiac symptoms
 Other eg murmur NYD
 Type (systolic/diastolic) & grade _____
 Other (Specify): _____

Other Indications (details):

Physician SIGNATURE: _____ Staff MD Name: _____

SEND REPORT TO: Name: _____
 (PLEASE PRINT) 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