

The Niagara Echo Group))))))

Echocardiography Requisition
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FAX COMPLETED REQUISITION or
Email to niagaraechogroup@gmail.com
...we will do the rest

Today's Date: _____

Appt date & time: _____

OHIP No. _____

LAST NAME _____

FIRST NAME _____

DOB _____

TELEPHONE # _____

CITY _____

Referring MD Name: _____ **Phone:** _____ **FAX:** _____

Copies: _____

History / Clinical information: (compare with previous)

Symptoms:

CHF palpitations atypical chest pain angina SOB COPD systolic murmur Abnormal ECG fever nyd

Ventricular Assessment:

LV systolic function Hypertension/ high BP previous MI previous CABG RV systolic function Pul HTN

Cardiomyopathy:

Hypertrophic ischemic dilated idiopathic

Source of Embolus:

TIA stroke Chronic Afib New onset Afib

Valvular Heart Disease R/O F/U Prosthetic Valve

Aortic

AS AR Bicuspid

Mitral

MR MVP MS

Tricuspid

TR TS

Pulmonic

PR PS

Signature of Referring MD _____