**The Niagara Echo Group)))))**

**Appt date & time:______________________________**

**Echocardiography Requisition**
**589 Lake St, Suite 203**
**St. Catharines, ON L2N 7L6**
**Office (905) 934-9070**
**Fax (905) 934-0346**
**www.niagaraechogroup.ca**

OHIP No.________________________________________

LAST NAME________________________________________

FIRST NAME________________________________________

DOB________________________

TELEPHONE #_______________________________________

CITY_____________________________________________

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

**Today's Date:____________________**

**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_____________________________________**

Cardiac Care Network Reviewed and Approved Echo Lab