Alexandra Marine and General Hospital
120 Napier Street
Goderich, ON N7A 1W5
T 519-524-8323 | **F 519-524-8532**

CARDIORESPIRATORY: ECHOCARDIOGRAM REQUISITION
Please fax completed requisition to 519-524-8532

Appointment Date: _____ **Time:** _____
(Month/Day/Year)

PATIENT INFORMATION: (please print or affix label)

_____ _____
Patient Last Name First Name

_____ _____ _____
Health # Version Expiry (Year/Month)

_____
D.O.B. (Year/Month/Day) Gender: ❑ Male ❑ Female

_____
Phone Number

ECHO INDICATIONS: (check boxes below)

- ❑ Chest pain
- ❑ Palpitations
- ❑ SOB
- ❑ HTN
- ❑ Presyncope/ Syncope
- ❑ TIA/Stroke
- ❑ Arrythmia
- ❑ Murmur
- ❑ Dyspnea (OE?)
- ❑ Cardiomyopathy
- ❑ CHF(with/without Edema)
- ❑ Valvular Stenosis of: _____
- ❑ Valvular Regurgitation of: _____
- ❑ Mitral Valve Prolapse
- ❑ Congenital Defect
- ❑ Prosthetic Heart Valve
- ❑ Endocarditis
- ❑ Abnormal CXR
- ❑ Abnormal ECG
- ❑ Other? (explain) _____

MEDICATIONS:

QUESTIONS YOU NEED ANSWERED BY THIS EXAM:

REFERRING PHYSICIAN:

Practitioner's Name (Print) _____ Address: _____

City: _____ Postal Code: _____ Tel: _____ FAX: _____

Physician's Signature: _____ Billing No: _____

Copy to: _____ Date: _____
(dd/mm/yyyy)