



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)**

- |  |   |
|--|---|
| <input type="checkbox"/> Chest pain          | <input type="checkbox"/> CHF(with/without Edema)          |
| <input type="checkbox"/> Palpitations        | <input type="checkbox"/> Valvular Stenosis of: _____      |
| <input type="checkbox"/> SOB                 | <input type="checkbox"/> Valvular Regurgitation of: _____ |
| <input type="checkbox"/> HTN                 | <input type="checkbox"/> Mitral Valve Prolapse            |
| <input type="checkbox"/> Presyncope/ Syncope | <input type="checkbox"/> Congenital Defect                |
| <input type="checkbox"/> TIA/Stroke          | <input type="checkbox"/> Prosthetic Heart Valve           |
| <input type="checkbox"/> Arrythmia           | <input type="checkbox"/> Endocarditis                     |
| <input type="checkbox"/> Murmur              | <input type="checkbox"/> Abnormal CXR                     |
| <input type="checkbox"/> Dyspnea (OE?)       | <input type="checkbox"/> Abnormal ECG                     |
| <input type="checkbox"/> Cardiomyopathy      | <input type="checkbox"/> 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)

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