northern health
the northern way of caring

All Sites and Facilities

Echocardiogram Requisition

Last Name:
First Name (Preferred Name):
Encounter #: NH #: Chart Created: ☐ Yes ☐ No
DOB: Gender: Age: Encounter Type:
Responsibility for Payment: PHN:
Primary Care Physician/Attending Physician:
PATIENT LABEL

Department Use Only. Requisition Received Date: Time:	Appointment: Date: Time:

Important: "*" fields must be completed to avoid delays in patient processing

Patient Information

Last Name*:	First Name*:	Personal Health Number*:
Address*:	City *: Province: Postal Code:	Date of Birth*: YYYY-MM-DD
Primary Phone*: Alternate Phone*:	Height (cm)*: Weight (kg)*: Gender:	Interpreter Required: ☐ No ☐ Yes Specify Language:

Bill To: ☐ MSP Insured ☐ ICBC ☐ WSBC ☐ Patient ☐ Other: _____ ICBC/WSBC Number:

Mobility Requirements: ☐ Ambulance ☐ Wheelchair ☐ Mechanical Lift ☐ Walk ☐ Stretcher ☐ Bed ☐ Bariatric

Isolation precations:_____ Infection Concerns: ☐ VRE ☐ Active TB ☐ MRSA ☐ C.diff ☐ Other:_____

☐ Outpatient ☐ Inpatient ☐ ER ☐ ICU ☐ Other:

Ordering clinician timeframe request: (**Note:** Medical Imaging department will review with the relevant clinical information provided using NH guidelines to determine the priority for scheduling the patient.)
☐ P1: within 24 hours ☐ P2: 2 to 7 days ☐ P3: 8 to 30 days ☐ P4: 31 to 60 days ☐ P5: specific date/follow up: _____

MI reviewed Priority P _____ Initials _____

Exam Category: ☐ Standard TTE ☐ TEE ☐ Pediatric less than 16 years of age ☐ Bubble Echocardiography
☐ Contrast Echocardiography ☐ Portable: Reason: _____

Please identify pertinent clinical information and patient history (reason for ordering ECHO). Requests without clinical information will be returned.

CHECK ALL THAT APPLY

☐ **Murmur**
- ☐ Systolic ☐ Diastolic

☐ **Aortic**:
- ☐ Stenosis ☐ Regurgitation
- ☐ Bicuspid

☐ **Mitral**
- ☐ Stenosis ☐ Regurgitation
- ☐ Prolapse ☐ Repair

☐ **Pulmonary**
- ☐ Stenosis ☐ Regurgitation

☐ **Tricuspid:**
- ☐ Stenosis ☐ Regurgitation

☐ **Cardiomyopathy**
- ☐ Dilated ☐ Hypertrophic
- ☐ Restrictive

☐ **Pulmonary Hypertension**
☐ **Systemic Hypertension**
☐ **Left Ventricular Hypertrophy**
☐ **Right Ventricular Hypertrophy**
☐ **Heart Failure**
☐ **Left Ventricular Function**
☐ **Previous EF** (If known): _____ %
Date: _____
☐ **Diastolic Function**
☐ **Myocardial Infarction:** Date: _____
- ☐ Anterior ☐ Inferior ☐ Unknown

☐ **Coronary Artery Bypass Graft**

☐ **Dysrhythmia**
- ☐ Atrial Fibrillation ☐ Other: _____

☐ **Source of Embolus**

☐ **Other Indications**
- ☐ Trauma ☐ Chemotherapy
- ☐ Pregnant ☐ CAD
- ☐ Pericardial Disease ☐ Aortic Aneurysm
- ☐ Infective Endocarditis

☐ **Symptoms**
- ☐ Shortness of Breath ☐ Chest Pain
- ☐ Fatigue ☐ Palpitations

Other: _____

Please place sticker on the back

Clinical question:

Prosthesis	Type / Manufacturer	Size	Date Implanted
Aortic			
Mitral			
Tricuspid			

Congenital Defect (attached operative report):
_____
☐ Pacemaker ☐ LVAD ☐ Defibrillator
☐ Other: _____

Ordering Clinician's Name (print)*: _____
Signature: _____
MSP #*: _____
Copies to*: _____
Phone #*: _____ ☐ Urgent report requested

Images: _____ **Cine**: _____ **Tech**: _____

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PATIENT LABEL

MEDICAL IMAGING PRIORITIZATION AND COMMUNICATION

Place flashcard label here

To be completed by Medical Imaging personnel:

☐ Radiologist required
Notes for booking staff:

To be completed by booking personnel:

Attempts to book:
1.

2.

3.

Notes:

Appointment date: _____ Time: _____