Interior Health

Inpatient Echocardiography Requisition

This requisition must be completed by the Ordering Physician before the exam will be scheduled

Patient Name ______________________

PixED# ______________________

Date ______________________

☐ **Scheduled (3)** ☐ **Urgent (2)** ☐ **Emergency (1)** *Physician must speak with Cardiologist / Radiologist for emergency cases*

Type of Echo Exam

☐ Standard TTE (echocardiogram) ☐ TEE (transesophageal echo)* ☐ Intra-Op TEE* ☐ Stress* ☐ Saline bubble*
☐ Definity Contrast* ☐ Pharmacological Stress* (Dobutamine / Persantine) ☐ Pericardiocentesis Echo*

* must be ordered by specialist

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

✓	Check all that apply
	Tricuspid
	stenosis
	regurgitation
	Cardiomyopathy
	dilated
	hypertrophic
	restrictive
	Pulmonary Hypertension
	Systemic Hypertension
	Left Ventricular Hypertrophy
	Right Ventricular function
	Heart Failure
	Left Ventricular Function
	Previous EF ______ **%** *(if known)* Date: ______

✓	Check all that apply
	Diastolic function
	Myocardial Infarction Date: ______
	☐ anterior ☐ inferior ☐ unknown
	Coronary Artery Bypass Graft
	Dysrhythmia
	☐ Atrial Fibrillation ☐ Other
	Source of embolus
	Other Indications ☐ trauma ☐ pericardial effusion ☐ pregnant ☐ chemotherapy ☐ infective endocarditis ☐ CAD ☐ aortic aneurysm ☐ transplant: type? ______ ☐ pericardial disease **Symptoms** ☐ shortness of breath ☐ chest pain ☐ fatigue ☐ palpitations ☐ syncope ☐ other ______

Prosthesis	Type / Manufacturer	Size	Date Implanted
Aortic			
Mitral			
Tricuspid			

Congenital Defect: *(attach operative report)*

Other History:

Patient Weight – *Required*	**Patient Height** – *Required*	☐ Patient is Mobile ☐ Patient requires assistance ☐ On Isolation? Type: ______

Physician Name *(print)*	Specialty	Copy Results To
Signature	Date	

PLEASE FAX COMPLETED FORM TO DIAGNOSTIC IMAGING:

Cranbrook:	**250-426-5610**	**Kamloops:**	**250-314-2326**	**Kelowna:**	**250-862-4155**
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