ECHOCARDIOGRAPHY DEPARTMENT

Booking Line **(705) 457-1392 Ext. 2381**
Fax Line **(705) 457-5173**

***** ***OUR DEPARTMENT WILL NEED*****
1. Your Ontario Health card.
2. This form.

APPT DATE & TIME: ____________________________

EXAM #

PATIENT NAME: ________________________________

DOB: ________________________________

TELEPHONE: ________________________________

REFERRING DOCTOR: ____________________________

FAMILY DOCTOR: ________________________________

CC DOCTOR: ________________________________

HEALTH CARD #: ________________________________

☐ Urgent ER/IP
☐ < 7 days
☐ > 7 days
☐ Discharged
☐ Admitted Rm # ____________
Extension ____________

** NON-AMBULATORY PATIENTS **MUST** ARRIVE ON A **STRETCHER**

ISOLATION ☐ YES ☐ NO
AND ☐ YES ☐ NO

ECHOCARDIOGRAPHY (Ultrasound of the Heart)

Exam may take up to 1 hour
No Preparation required

Indications/Relevant Medical History:

☐ Atrial Fib ☐ Chest Pain/CAD ☐ Hypertension ☐ Murmur ☐ Palpitations
☐ PE ☐ Post MI ☐ SOB ☐ Stroke ☐ TIA
☐ Pericardial Disease ☐ Cardiac Mass ☐Aortic Disease ☐ Syncope
☐ Cardiomyopathy ☐ Pulmonary Disease ☐ Other ________________

☐ Valve Disease (please circle) - Regurgitation Stenosis Other

For Inpatient Use **Nurse Verified:** ☐ Medical Directive ☐ Chart Order	Appointment Date	Time	Medical Record #

PHYSICIAN'S SIGNATURE: ____________________ **Date:** ________________________
(Must be ordered & signed by a physician)

Please respect that the hospital supports a **FRAGRANCE FREE** environment.