HALIBURTON HIGHLANDS HEALTH SERVICES

Echocardiography

Booking Line: 705 – 457 – 1392 Ext. 2381

Fax Line: 705 – 457 – 1071

Patient Name: _____

Birthdate: _____

Phone: _____

Referring Doctor: _____

Family Doctor: _____

CC Doctor: _____

Health Card #: _____

- ☐ Urgent ER/IP
- ☐ < 7 Days
- ☐ > 7 Days
- ☐ Discharged
- ☐ Admitted Room #: _____

ECHOCARDIOGRAPHY (Ultrasound Of The Heart)

Indications/Relevant Medical History:

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

☐ Other _____

☐ Valve Disease (please circle) Regurgitation Stenosis Other

Physician's Signature: _____ **Date:** _____

(must be ordered & signed by a physician)