PORT PERRY IMAGING
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Accredited by CNN for Echocardiography Since 2016
Accredited for Mammography by the Canadian Association of Radiologist Since 1997
Accredited for Ultrasound by the American College of Radiology Since 1999
Fetal Medicine Foundation, Nuchal Translucency Screening Centre Since 2005
Ontario Breast Screening Program - Port Perry Affiliate Since 1997
Accredited for Bone Density by the Ontario Association of Radiologists Since 2008

OHIP Requires you present your health card and requisition at each visit

This requistion form can be taken to any licensed facility providing healthcare services including hospitals and IHFs.

Name: _____ **Date of Birth:** _____ ☐ M ☐ F ☐ Other

Address: _____ **Heath Card/Version Code:** _____

Phone: (day) _____ **(eve.)** _____ **Your Appointment:** _____ **at** _____

Please make necessary childcare arrangements during your exam; Children will not be allowed in the exam room

☐ Echocardiogram 2D and Doppler with Colour
(*Contrast Echo at the discretion of the Interpreting Physician)*

☐ Bi-Lateral Carotid Doppler

☐ Emergent (within 24 hours)
☐ Urgent/Semi-urgent (7 days)
☐ Scheduled/Non-urgent (30 days)
Height: _____ Weight: _____
Latex Allergy: ☐ No ☐ Yes
Infections: _____
(eg. VRE/MRSA/C-Diff/TB)

REQUESTS WITHOUT CLINICAL INFORMATION WILL BE RETURNED

Identify: Patient History, Pertinent Clinical Information and reason(s) for ordering Echo (CHECK ALL THAT APPLY)

Symptoms:
☐ Short of breath ☐ Syncope ☐ Chest Pain ☐ Palpitations ☐ Fatigue ☐ Other _____

☐ **Murmur**
- ☐ systolic
- ☐ diastolic

☐ **Aortic**
- ☐ stenosis
- ☐ regurgitation
- ☐ bicuspid

☐ **Mitrial**
- ☐ 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**

☐ **Transplant: type:** _____

☐ **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
☐ CAD ☐ Pericardial disease
☐ Pregnant ☐ Aortic aneurysm
☐ Infective endocarditis
☐ Pericardial effusion

Prosthesis	Type/Manufacturer	Size	Date Implanted
Aortic			
Mitrial			
Tricuspid			

Congenital Defect: (attach operative report)

Other History:

CLINICAL INFO: _____ **REF. MD.:** _____ **Physician Signature:**

Billing; _____

CC: _____ **Date:** _____