



Capital Health

Echocardiogram Request

Dartmouth General Hospital

Fax: (902) 465-8489

Phone: (902) 465-8302

QEII and Cobequid

Echocardiography Fax: (902) 473-2973 / Phone: (902) 473-3600

Echocardiography – Inpatient VG only Fax: (902) 473-1484

Requisition will be returned if the following information is not provided

PATIENT INFORMATION			
Health Card # _____		DOB: yyyy/mm/dd _____	
HUN # _____			
Surname _____	First Name _____	Middle Initial _____	Tel # _____
Address _____		City _____	Postal Code _____
MRSA / VRE <input type="checkbox"/> Y <input type="checkbox"/> N			

Please indicate type of request:

Elective

Semi-Urgent

Urgent

Patient Height _____

Patient Weight _____

Inpatient Mode of Transport:

Ambulatory

Chair

Stretcher

EXAMINATION REQUESTED		
<p>Transthoracic Echo</p> <p><input type="checkbox"/> Full Study</p> <p><input type="checkbox"/> LV Contrast</p> <p><input type="checkbox"/> Bubble Study</p> <p><input type="checkbox"/> Limited Study (only one non-severe disorder)</p>	<p>Transesophageal Echo</p> <p>(see checklist below)</p> <p><input type="checkbox"/> TEE</p>	<p>Stress Echo</p> <p><input type="checkbox"/> Dobutamine (see checklist below)</p> <p><input type="checkbox"/> Exercise (see checklist below)</p>
<p>Please note: Elective wait times may be long. Please check the following website for updated wait times: http://dom.medicine.dal.ca/waittimes/Cardiology/Cardiology.htm</p>		

HISTORY AND PROVISIONAL DIAGNOSIS

TEE Information	Circle One	Dobutamine Information	Circle One	Exercise Stress Echo Information	Circle One
Patient able to consent	Y N	Patient able to consent	Y N	Patient able to walk on treadmill	Y N
Patient able to swallow	Y N	Current or recent ACS	Y N		
Hx of esophageal disease	Y N	Current or recent Ventricular arrhythmia	Y N		
Patient able to lay on left side	Y N				

REQUESTING PHYSICIAN INFORMATION		
Requesting Physician's name: _____	Signature: _____	
Telephone: _____	Fax: _____	Date: (YYYY/MM/DD) _____
Research Cost Center #: _____		

