SAULT AREA HOSPITAL
HÔPITAL DE SAULT-SAINTE-MARIE

DEMOGRAPHIC LABEL

CARDIAC ULTRASOUND REQUISITION

Please check off indication for the Echocardiogram.
Clinical History is to be provided as well. Incomplete forms will be returned.

☐ In Patient ☐ Out Patient

Select Indication(s):

☐ Heart Murmur
☐ Prosthetic Heart Valve
☐ Cardiac Mass
☐ Interventional Procedure
☐ Thoracic Aorta Disease
☐ Arrhythmias/Syncope/Palpitations
☐ Dyspnea/Edema/Cardiomyopathy
☐ Native Valvular Stenosis
☐ Infective Endocarditis
☐ Hypertension
☐ Pulmonary Disease
☐ Before Cardioversion
☐ Native Valvular Regurgitation
☐ Pericardial Disease
☐ Known or Suspected Mitral Valve Prolapse
☐ Chest pain/CAD
☐ Neurologic / Embolic Event/ CVA
☐ Suspected Structural Heart Disease
☐ Congenital/Inherited Cardiac Structural Disease

Height _____ **Weight** _____kg **BP** _____

Clinical Information Mandatory:

_____

_____

_____

_____

Referring Physician: _____
(Please Print Name)

Physician Signature: _____

Please fax to SAH :705-759-3714