SAULT AREA HOSPITAL
HÔPITAL DE SAULT-SAINTE-MARIE
iCare

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

☐ Transthoracic (TTE)

☐ Transesophageal (TEE)

☐ Exercise Stress Echo

☐ Yes ☐ No The patient is on B-blockers The patient is on B-blockers or rate limiting Ca Channel medication and will advise patient to hold medication on the day of the test – recommended to allow patient to reach target heart rate and have a diagnostic stress test

☐ Yes ☐ No The patient is on B-blockers or rate limiting Ca Channel medication and will not hold medication. Perform the test while patient is on medication

☐ Yes ☐ No The patient has a pacemaker or defibrillator

Select Indication(s):

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

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

Clinical Information Mandatory: _____

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_____

Referring Physician: _____
(Please Print Name)

Physician Signature: _____

Please fax to SAH :705-759-3714