ADULT ECHOCARDIOGRAPHY AND INTERNAL MEDICINE
10104-97 Ave Unit #201
Grande Prairie, AB T8V 7X6
CANADA

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ECHOCARDIOGRAM REQUISITION

Date ______________________________ Echo Appointment Date ______________________________

Patient's Name ______________________________ ______________________________
LAST NAME FIRST NAME

Date of Birth ______________________________ Gender ______________________________
DAY / MONTH / YEAR

Health Care Number ______________________________

Phone Number ______________________________ (Cell/Work No.) ______________________________

Address ______________________________

Reason for Test / Diagnosis ______________________________

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Priority of Test: Routine______________ Urgent ______________

Indication: ____________ Left Ventricular Function ______________ Region Wall Motion ______________

Valvular Heart Disease (known or suspected): MV____________ AV____________ TV____________ PV ____________

Other (please indicate) ______________________________

Is a Prosthetic Valve Present? Yes*______________ No______________

*Type and Size ______________________________ Date of Operation ______________________________

Is Pacemaker or Defibrillator Present? Yes ______________ No______________

REFERRING PHYSICIAN

____

Fax Number ______________________________

Address ______________________________

____

____

FAMILY PHYSICIAN / copies to:

____

Fax Number ______________________________

Address ______________________________

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PLEASE BRING YOUR HEALTH CARE CARD TO YOUR APPOINTMENT.