Brockville General Hospital

ULTRASOUND – ECHOCARDIOGRAPHY REQUISITION

PLEASE FAX COMPLETED REQ TO 613-345-8324

As of November 2019

Last Name: ____________________ First Name: ____________________ Date of Birth: _______________

Address: ________________________________ City: _______________ Postal Code: ________________

Phone Number: _______________ Health Card #: _______________________________ VC: __________

If WSIB – Claim # __________________________ Date of Injury: __________________________________

Ultrasound/Echo Coding For Office Use Only	**P1:_____ Within 24 Hours**	**P2:____ Within 1 Week**	**P3:____ Within 1 Month**	**P4:____ Elective**

Allergies: ____

Medications: ____

Clinical Information: ____

ULTRASOUND

Obstetrical	General	Vascular	Musculo-Skeletal
☐ Detailed OB Scan (18-20 weeks)	☐ Abdomen	☐ Carotids	☐ Right Shoulder/Rotator Cuff
☐ High Risk	☐ Abdomen/Pelvis	☐ Portal Vein Doppler	☐ Left Shoulder/Rotator Cuff
☐ BPP	☐ Pelvic	☐ Right Venous Leg	☐ Right Knee/Baker's Cyst
☐ BPP + EFW	☐ Pelvis/Appendix	☐ Left Venous Leg	☐ Left Knee/Baker's Cyst
☐ R/O Ectopic	☐ Pelvic +/- TV	☐ Right Venous Arm	☐ Right Achilles Tendon
☐ Dating OBS	☐ Transvaginal	☐ Left Venous Arm	☐ Left Achilles Tendon
Breast	☐ Renal	☐ Screening ABI(Legs)	☐ Right Breast Biopsy
☐ Right Breast	☐ Bladder/Prostate	☐ Full ABI (For Vascular Surgery Consult)	☐ Left Breast Biopsy
☐ Left Breast	☐ Pre / Post Void	☐ Right Arterial Arm	☐ Lymph Nodes
☐ Right Axilla	☐ Groins/Hernias	☐ Left Arterial Arm	Location:_______________________
☐ Left Axilla	☐ Thyroid/Neck		☐ Other:_______________________
	☐ Testicular		

ECHOCARDIOGRAPHY

☐ Heart Murmur
☐ Valvular Regurgitation
☐ Valvular Stenosis
☐ Hypertension
☐ Neurologic or Other Possible Embolic Events
☐ Congestive Heart Failure
☐ Infective Endocarditis
☐ Edema
☐ Coronary Artery Disease
☐ Chest Pain
☐ Bubble Study (for PFO/ASD/VSD)
☐ Dobutamine Echo
☐ Stress Echo

☐ Cardiomyopathy
☐ Baseline LV function or periodic Review when using cardiotoxic Drugs (chemotherapy)

Prosthetic Heart Valve(s)

Valve Type: ☐ Tissue ☐ Mechanical

Location:
☐ Aortic ☐ Mitral
☐ Tricuspid ☐ Pulmonic

Date (year): _______________

☐ Known or suspected Mitral Valve Prolapse

☐ Pulmonary Disease
☐ Pulmonary Embolism
☐ Dyspnea
☐ Pericardial Disease
☐ Suspected Structural Heart Disease
☐ Cardiac Mass
☐ Palpitations / Arrhythmia
☐ Syncope
☐ Pre-Pacemaker / ICD
☐ Pre-Cardioversion
☐ Thoracic Aortic Disease
☐ Congenital or Inherited Structural Heart Disease

Ordering Provider Name: ___________________________ (Please print)

Ordering Provider Signature: ___________________________(Print and sign) **Date:** ______________

Booking Office Use:

Date: ________________________________ **Time:** _______________ **Confirmed:** __________________