Brockville General Hospital

**ECHOCARDIOGRAPHY/CARDIOVASCULAR SERVICES REQUISITION**

**PLEASE FAX COMPLETED REQ TO (613) 345-8330**

As of November 2026

## PATIENT INFORMATION

| Last Name | First Name | Date of Birth | YYYY | MM | DD |
|---|---|---|---|---|---|
| | | | | | |

| Address | City | Postal Code |
|---|---|---|
| | | |

| Phone | E-mail Address | Health Card Number | Ver Code |
|---|---|---|---|
| | | | |

## CLINICAL INFORMATION

☐ Urgent ☐ Non-Urgent

## ECHOCARDIOGRAPHY (BY APPOINTMENT ONLY)

☐ Bubble Study (for PFO/ASD/VSD) ☐ Echocardiogram ☐ Dobutamine Echo

☐ Exercise Stress ☐ Stress Echo

## CLINICAL INDICATIONS

☐ Heart Murmur
☐ Valvular Regurgitation
☐ Valvular Stenosis
☐ Hypertension
☐ Neurologic or Other Possible Embolic Events
☐ Congestive Heart Failure
☐ Infective Endocarditis
☐ Edema
☐ Coronary Artery Disease
☐ Chest Pain

☐ 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

## CARDIOVASCULAR SERVICES

**No Appointment Required**
☐ Electrocardiogram (ECG)
☐ ECG with Rhythm Strip

**By Appointment Only**
☐ Holter Monitor

**Short**
☐ 24hrs ☐ 48hrs ☐ 72hrs

**Long**
☐ 7 Days ☐ 14 Days

**Long Term Holter Indications** (mandatory for 7 and 14 days Holters and patient must return on day 7 for 14 days Holters)

☐ Stroke/TIA investigations
☐ AF/PAF
☐ SVT
☐ Pauses
☐ Risk of Sudden Cardiac Death
☐ Syncope or Pre-Syncope episodes
☐ Infrequent Symptoms

## CLINICIAN INFORMATION

Date of the Request (YYYY/MM/DD): _____/____/____

| Requesting Clinician Name (PRINT First and Last Name) | Clinician Fax Number |
|---|---|
| | |

| Clinician Signature | Clinician Phone Number |
|---|---|
| | |

REQUISITIONS WITHOUT A LEGIBLE NAME, SIGNATURE AND FAX NUMBER WILL BE RETURNED, WHICH MAY CAUSE DELAYS IN PATIENT CARE

| Copy Report to (PRINT First and Last Name) | Copy to Fax Number |
|---|---|
| | |

## CARDIOVASCULAR USE ONLY

**Echo Coding** **P1:____ Within 24 Hours** **P2:____ Within 1 Week** **P3:____ Within 1 Month** **P4:____ Elective**

**Date (YYYY/MM/DD): _____/____/____ Time: _____ Confirmed: _____**