HALIBURTON HIGHLANDS HEALTH SERVICES

Leaders in Innovative Rural Health Care

ECHOCARDIOGRAPHY DEPARTMENT

Booking Line **(705) 457-1392 Ext.2381**

Fax Line **(705) 457-1071**

***** *OUR DEPARTMENT WILL NEED******

1. Your Ontario Health card.
2. This form.

APPT DATE & TIME: _____ EXAM #

PATIENT NAME: _____

DOB: _____

TELEPHONE: _____

REFERRING DOCTOR: _____

FAMILY DOCTOR: _____

CC DOCTOR: _____

HEALTH CARD #: _____

☐ Urgent ER/IP
☐ < 7 days
☐ > 7 days
☐ Discharged
☐ Admitted Rm # _____
Extension _____

** NON-AMBULATORY PATIENTS **MUST** ARRIVE ON A **STRETCHER**

ISOLATION ☐ YES ☐ NO
AND ☐ YES ☐ NO

ECHOCARDIOGRAPHY (Ultrasound of the Heart)

Exam may take up to 1 hour
No Preparation required

Indications/Relevant Medical History:

☐ Atrial Fib ☐ Chest Pain/CAD ☐ Hypertension ☐ Murmur ☐ Palpitations
☐ PE ☐ Post MI ☐ SOB ☐ Stroke ☐ TIA
☐ Pericardial Disease ☐ Cardiac Mass ☐ Aortic Disease ☐ Syncope
☐ Cardiomyopathy ☐ Pulmonary Disease ☐ Other _____

☐ Valve Disease (please circle) - Regurgitation Stenosis Other

For Inpatient Use				
Nurse Verified: ☐ Medical Directive ☐ Chart Order		Appointment Date	Time	Medical Record #

PHYSICIAN'S SIGNATURE: _____ **Date:** _____
(Must be ordered & signed by a physician)

Please respect that the hospital supports a **FRAGRANCE FREE** environment.