Hôpital Régional de Pembroke Regional Hospital

Pembroke Regional Hospital
ECHO IMAGING REQUISITION

Booking / Information / Cancellations
Phone: 613-732-4141 Fax: 613-732-6349
705 Mackay Street, Pembroke ON K8A 1G8

Addressograph

TEST DATE: _____ **TIME:** _____ **PRECAUTIONS:** _____.

PRIORITY: ☐ **Inpatient** – Unit: _____ Room #: _____	☐ Ambulatory ☐ Wheelchair ☐ Stretcher ☐ Portable	☐ **Outpatient** – Urgency: ☐ Less than two weeks ☐ Less than 1 month ☐ Elective

Surname	First Name	Maiden Name

Date of Birth (yyyy/mm/dd)	Gender ☐ Male ☐ Female	Provincial Insurance Number	Version Code	Expiry Date

Address	City	Province	Postal Code

Telephone Number: (Home): (Alternative):

EXAMINATION(S) REQUESTED

CARDIAC STRUCTURE AND/OR FUNCTION ASSESSMENT
☐ Echocardiography (colour/Doppler)

CLINICAL INFORMATION

REASON FOR REQUEST: *mandatory

*Height _____ cm

*Weight _____ kg

☐ Chest Pain
☐ Dyspnea
☐ Palpitations
☐ Arrhythmia
☐ Syncope

☐ Post PCI/CABG
☐ History of MI
☐ Stroke/TIA
☐ Heart Function/Failure
☐ Murmur/Valve Disease

Pacemaker patient? ☐ Yes ☐ No
Defibrillator patient? ☐ Yes ☐ No

Diabetic? ☐ Yes ☐ No
Metformin? ☐ Yes ☐ No

ALLERGIES:

MEDICATIONS: Please list medications.

Physician's Name (print)	Physician's Signature
Resident's Name (print)	Physician's Billing No.
Telephone No.	Fax No.

Copy of report to:	Family Physician
	Other Physician(s)

FOR OFFICE USE ONLY

Protocol/Procedure Code

Stores # 184110