BRANT COMMUNITY HEALTHCARE SYSTEM

ECHOCARDIOGRAM, ECG, HOLTER AND STRESS REQUISITION

200 Terrace Hill St., Brantford ON N3R 1G9

Tel: 519-751-5599 Fax: 519-751-5582

For Office Use Only:
Appointment Date/Time:

REFERRING CLINICIAN INFORMATION		PATIENT INFORMATION	
Name:		Health Card / Version / DOB (D D M M Y Y Y Y) / Sex (M F U)	
OHIP Billing Number:		First Name:	Last Name:
Address		Address:	
City/Prov:	Postal Code:	City/Province:	Postal Code:
Phone:	Fax:	Phone Number:	Secondary Phone Number:
Signature:		WSIB Claim #:	Secondary Insurance:
Copies to:		**Patient Height:**	**Patient Weight:**

Does Patient Require Assistance? ☐Mechanical Lift ☐ Wheelchair ☐Language Interpreter - Specify:

EXAM REQUESTED (BY APPOINTMENT ONLY) **INCOMPLETE REQUISITIONS WILL BE RETURNED**

ECHOCARDIOGRAM (18 years and older)

☐**ECHOCARDIOGRAM**
☐**ECHOCARDIOGRAM WITH CONTRAST**
☐**ECHOCARDIOGRAM WITH SALINE (Bubble Study)**

STRESS/ECG/HOLTER MONITOR

☐**EXERCISE STRESS**
*patient must be able to walk on a treadmill
☐ **ELECTROCARDIOGRAM (ECG)**
☐ **HOLTER MONITOR ☐48 hr☐72hr**

STANDARD INDICATIONS FOR ECHOCARDIOGRAM

☐Acute Coronary Syndrome
☐Baseline or Left Ventricular function surveillance for chemotherapy
☐Cardiac Mass
☐Cardiomyopathy
☐Chest Pain
☐Congenital or Inherited Structural Heart Disease
☐Congestive Heart Failure
☐Dyspnea
☐Edema
☐Heart Murmur
☐Hypertension
☐Infective Endocarditis
☐Interventional Procedures
☐Known or Suspected Mitral Valve Prolapse
☐Palpitations/ Arrhythmia
☐Pericardial Disease
☐Post Myocardial Infarction
☐Pre-Cardioversion
☐Pre-Pacemaker/ICD
☐Prosthetic Heart Valve
☐Aortic ☐Mitral
☐Tricuspid ☐Pulmonic
Date (year) _____
☐Pulmonary Disease
☐Pulmonary Embolism
☐Stroke / TIA - Rule out source of embolic event
☐Suspected Structural Heart Disease
☐Syncope
☐Thoracic Aortic Disease
☐Valvular Regurgitation
☐Valvular Stenosis
☐Other _____

INDICATIONS FOR STRESS/ECG/HOLTER

☐Cardiac Rehabilitation
☐Chest Pain
☐Dizzy Spells
☐Functional Capacity
☐Pacemaker/Defibrillator
☐Palpitations
☐Post Myocardial Infarction (MI)
☐Post Percutaneous Coronary
☐Intervention /Coronary Artery
☐Bypass Grafting (PCI/CABG)
☐PVC's
☐R/O Atrial Fibrillation
☐Shortness of Breath
☐Syncope

CLINICAL HISTORY: REASON FOR ORDER

Previous Surgeries:

Related Previous Imaging: ☐ Yes ☐ No If yes, Where: **Please attach previous if not completed at BGH.**

Please include all relevant patient history including previous reports or consult notes as appropriate.