

CARDIOLOGY DIAGNOSTICS REQUISITION

Depending on wait times, patients may be scheduled at any of our hospital sites in the Niagara region

PHONE: 905-378-4647

- St. Catharines Site Ext: 46350 Fax: 905-323-7560
- Niagara Falls Site Ext: 54812 Fax: 905-358-7438
- Welland Site Ext: 33280 Fax: 905-732-9537

OUTPATIENT

- NEXT AVAILABLE
- WITHIN 1-2 WEEKS
- ROUTINE

APPOINTMENT DATE/TIME/SITE: _____
DD / MM / YYYY HH : MM SITE

PATIENT INFORMATION (PLEASE PRINT)

PATIENTS LAST NAME		PATIENTS FIRST NAME		OHCN/OHIP#	VERSION CODE
ADDRESS		CITY		DATE OF BIRTH (DD/MM/YYYY)	GENDER
MOBILE PHONE (PREFERRED CONTACT METHOD)	HOME PHONE	PROVINCE	POSTAL CODE	<input type="checkbox"/> WSIB CLAIM #:	
CAN THE PATIENT COME IN ON SHORT NOTICE? <input type="checkbox"/> YES <input type="checkbox"/> NO		DOES THE PATIENT HAVE ANY ACCESSIBILITY ISSUES? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, SPECIFY:			
CAN WE CONTACT YOU BY EMAIL? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, PLEASE PROVIDE YOUR EMAIL ADDRESS:					

IT IS THE REFERRING PROVIDERS RESPONSIBILITY TO NOTIFY THE PATIENT OF APPOINTMENT DETAILS

ORDERING PROVIDER INFORMATION (PLEASE PRINT)

ORDERING PROVIDER NAME	ADDRESS	COPIES TO
PHONE NUMBER	CITY	URGENT RESULTS CONTACT #
SIGNATURE	PROVINCE	POSTAL CODE
		FAX NUMBER

ECG (No preparation required) **STRESS ECG** (Preparation required)

Request specific timing of test? _____

- ECG
 - STRESS ECG (At St. Catharines Site – this study may be ordered by a non-cardiologist)
- Preparation for Stress ECG:**
- Please have nothing to eat or drink for two hours before the test.
 - Please wear comfortable clothing (ladies, please wear a two-piece outfit with short sleeves).
 - Please wear walking or running shoes.
 - Please bring a list of medications.

Contraindications to Stress ECG:

- Severe aortic stenosis
- Unstable angina/angina at rest
- Left bundle branch block
- Paced rhythm
- Patient unable to walk on the treadmill

HOLTER MONITORING (No preparation required)

Request specific timing of test? _____

- 24 HOUR MONITORING 48 HOUR MONITORING 72 HOUR MONITORING OTHER: _____
- DOES THE PATIENT HAVE A PACEMAKER/ICD? YES NO

ECHOCARDIOGRAPHY (No preparation required)

Request specific timing of test? _____

<ul style="list-style-type: none"> <input type="checkbox"/> ADULT ECHOCARDIOGRAM (Specify) <ul style="list-style-type: none"> <input type="checkbox"/> COMPLETE (Does Not Include Bubble/Definity) <input type="checkbox"/> LIMITED <input type="checkbox"/> IV AGITATED SALINE CONTRAST (Bubble Study) <input type="checkbox"/> IV CONTRAST <input type="checkbox"/> PAEDIATRIC ECHOCARDIOGRAM (Specify) <ul style="list-style-type: none"> <input type="checkbox"/> COMPLETE (Does Not Include Bubble/Definity) <input type="checkbox"/> LIMITED <input type="checkbox"/> STRESS ECHOCARDIOGRAM (See Preparation for Stress ECG) 	<ul style="list-style-type: none"> <input type="checkbox"/> TRANSESOPHAGEAL ECHOCARDIOGRAM (TEE) <p>Indication: (Choose One)</p> <input type="checkbox"/> ENDOCARDITIS <input type="checkbox"/> CARDIAC SOURCE OF EMBOLUS <input type="checkbox"/> SHUNT <input type="checkbox"/> PRE ABLATION <input type="checkbox"/> NATIVE VALVE DISEASE <input type="checkbox"/> PROSTHETIC VALVE DISEASE <input type="checkbox"/> OTHER (List in patient history) <p>Mandatory Questions:</p> <p>Is the patient on CPAP? <input type="checkbox"/> YES <input type="checkbox"/> NO Are there any respiratory concerns for sedation? <input type="checkbox"/> YES <input type="checkbox"/> NO History of difficulty swallowing? <input type="checkbox"/> YES <input type="checkbox"/> NO ↳ If yes, specify: _____ History of cirrhosis/ esophageal/ gastric disease? <input type="checkbox"/> YES <input type="checkbox"/> NO Patient on anticoagulants? <input type="checkbox"/> YES <input type="checkbox"/> NO Recent upper GI bleed? <input type="checkbox"/> YES <input type="checkbox"/> NO ↳ If yes, specify: _____ Previous upper endoscopy? <input type="checkbox"/> YES <input type="checkbox"/> NO Can the patient provide informed consent? <input type="checkbox"/> YES <input type="checkbox"/> NO ↳ If yes, any abnormalities in the esophagus? _____ ↳ If no, a substitute decision maker must come with the patient to the appointment.</p>
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PATIENT HISTORY: Please include previous imaging, reports and relevant laboratory studies required for TEEs

PLEASE NOTE: INCOMPLETE REQUISITIONS WILL BE RETURNED/FAXED BACK WITHOUT AN APPOINTMENT