|  |
| --- |
|  **Echocardiography Requisition****Louise Marshall Hospital****Fax Completed requisition to 519-943-0980** |
| **PATIENT INFORMATION:** Last Name: First Name: DOB: (dd/mm/yyyy) Health Card Number: Address: *Street* *City Province* *Postal Code Phone:* **Height:\_\_\_\_\_\_\_\_\_\_\_\_\_ Weight:\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  | **REFERRING PHYSICIAN:** Name: Address: *Street* *City Province Postal Code* *Phone: Fax:* Additional copies:   |
|  **For urgent requests please contact the department directly 519-323-2210 x 74701** |
| **Urgent** **Elective** **Is this a pre-operative assessment?**  **No**  **Yes  *Date of Surgery*** *(if known)****: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*****Translator Required?**  **No**  **Yes  *If yes, Specify Language: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*** |
| **ECHOCARDIOGRAPHY**  |  **Transthoracic Echocardiogram (no patient prep)**  |
| **INDICATION: *Check all that apply \*\* Requisitions without appropriate indication/clinical information will be returned\*\**** ** Prior MI  Cardiac Cath  CABG** ** Valve Replacement  Mechanical  Tissue *Model:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*** ** Chest pain  Dyspnea  Palpitations  AFib  Syncope**  ** Murmur*:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*** ** LV dysfunction  Cardiomyopathy  Aortic Disease  Source of embolus  Pericardial Disease** ** Chemotherapy** ** LVH  RV dysfunction  Congenital  Pulmonary HTN**  ** Valve Disease: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** ** Cardiac screening for asymptomatic patients with multiple cardiovascular risk factors (*select all that apply)*:** **Smoker Diabetic Dyslipidemia Hypertension  Stroke/TIA  PVD  Family History CAD**  ** Abnormal ECG** **CLINICAL INFORMATION:**  |

**Physician’s Signature: Date:** \_

**Office Use Only**

**Date Received: Scheduled Appointment: Patient Notified** 

|  |
| --- |
| ***Suggested Chest Pain Assessment Algorithm (Excluding Acute Coronary Syndromes)*** |
| **STEP 1. Estimate Pretest Probability of Obstructive Coronary Disease as the cause for the patient’s chest pain:** |
| **Chest Pain Characteristics:**1. Substernal chest discomfort, with characteristic quality and duration
2. Provoked by exertion or emotional stress
3. Relieved by rest and/or Nitroglycerine
 |

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Non-Anginal** **Chest Pain****≤ 1 *of* 3** | **Atypical Chest Pain****2 *of* 3** | **Typical Anginal** **Chest Pain****3 *of* 3** |
| **Age** | *Male* | *Female* | *Male* | *Female* | *Male* | *Female* |
| 30-39 | 4% | 2% | 34% | 12% | 76% | 26% |
| 40-49 | 13% | 3% | 51% | 22% | 87% | 55% |
| 50-59 | 20% | 7% | 65% | 33% | **93%** | 73% |
| 60-69 | 27% | 14% | 72% | 51% | **94%** | **86%** |

 |
| **STEP 2. Determine the appropriate non-invasive risk stratification method:** |
|  |
| **Stress Test with Consultation & +/- Consultation Services:*** Appropriate for the evaluation of patients presenting with chest pain or dyspnea with intermediate to high pre-test probability of obstructive CAD
* Cardiovascular screening for asymptomatic patients with multiple cardiovascular risk factors
* Pre-operative cardiac assessment, in patients with multiple cardiovascular risk factors or known CAD, not currently followed by a Cardiologist, ***WHEN*** it will change management
* +/- Consultation means a consultation will be provided in the event of a high risk study
* Stress test with Consultation service is ***NOT*** appropriate for patients who are currently being followed and managed by a Cardiologist. In this case, either refer directly to that physician’s office or order a test only, with the results copied to the patient’s usual Cardiologist
 |