CARDIAC DIAGNOSTICS REQUISITION

Winchester District Memorial Hospital

Phone: 613-774-2420 ext.6496
Fax: **613-774-7233**

Name:

Address

City Postal Code

Phone (Day): (Evening):

DOB: /DD /MM /YY ❑ M ❑ F

OHIP # Version Code Exp Date

Date:_____

❑ Out Patient ❑ ER/In Patient Room:_____

❑ Isolation-Type: _____

❑ Walking ❑ Stretcher ❑ Wheelchair

Referring physician (please print)**:**_____

Phone # (required): _____

Copy to:_____

Priority:

❑ **Stat** ❑ **Urgent** ❑ **Routine**

❑ **ECG**

❑ **Treadmill Stress Test**

❑ **Echocardiogram**

- ❑ Oncology protocol (Echo every _____ months x 1 year)

❑ **Holter Monitor**

- ❑ 48 hour ❑ 7 day
- ❑ 72 hour ❑ 14 day

❑ **Carotid Ultrasound**

Indications

- ❑ Chest pain
- ❑ Dyspnea
- ❑ Palpitations
- ❑ Murmur
- ❑ Syncope/Presyncope
- ❑ Valve disease
- ❑ Abnormal ECG
- ❑ Arrhythmias
- ❑ Heart function / failure
- ❑ Prosthetic valve function
- ❑ Bruit
- ❑ CVA / TIA
- ❑ Risk Factors
- ❑ History of MI date: _____
- ❑ Post PCI / CABG date: _____

Physician signature: _____

MD OHIP Billing #:_____

Other Indications / Clinical History:

_____

_____

_____

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_____

FOR USE BY CARDIOLOGY DEPARTMENT

*****PLEASE FAX PREVIOUS ECHO OR CAROTID REPORT ALONG WITH THE REQUISISTION***** May 2018