McMaster Children's Hospital

Please Print Clearly →

PEDIATRIC ECHOCARDIOGRAM REQUISITION

Patient's Last Name | First Name

Address – Street | City | Postal Code

Telephone: ( ) | Ext.

Cell Phone: ( )

Date of Birth (yyyy/mm/dd) | Age | Gender M F

HIN | Family Physician

Date: (yyyy/mm/dd) _____

Referring Physician _____

Physician's Signature _____

Phone: _____ (ext) _____

Fax: _____

OHIP Billing Number _____

Patient's M # _____

__ Interpreter required
→ Language _____

__ CAS / FACS Involvement – (case manager & contact information) _____

Parent or Guardian Name: _____ **Email:** _____

Current Medication List: Faxed with Requisition **Current Allergy List:** Faxed with Requisition

Request Appointment Date of: (yyyy/mm/dd) _____ **OR:** Today, Tomorrow, 1 Week, 2 Weeks, 1 Month, 3 Months, 6 Months (follow-up)

Priority: __ Routine __ Urgent **** Please page the pediatric cardiologist on call if requested appointment date is within 1 week ****

Previous Echo: __ Yes, at HHS __ Yes, outside HHS __ No __ Unknown

Anatomical Diagnosis:

Normal, Unknown, Anomalous Pulmonary Venous Return, Aortopulmonary Window
Aortic Arch Abnormalities, Atrial Septal Defect, Atrioventricular Septal Defect
Bicuspid/Dysplastic Aortic Valve, Cardiomyopathy, Common Arterial Trunk and Hemi-Truncus
Coronary Anomoly, Cor Triatriatum, Double Outlet Right Ventricle
Ebstein's / Tricuspid Dysplasia, Hypoplastic Left Syndrome, Isomerism
LVOT Obstruction, Mitral Valve Dysplasia / Prolapse, Patent Ductus Arteriosus, Pericarditis
Pulmonary Atresia, Pulmonary Valve Dysplasia, Tetralogy of Fallot
Transposition of Great Arteries, Tricuspid Atresia, Tumour (Cardiac), Vascular Ring
Ventricular Septal Defect, Other (please specify) _____

Reason for Exam:

Known Congenital Heart Defect, Abnormal Chest X-ray, Arrhythmia, Bubble Study
Cardiac Murmur, Chemotherapy Exposure, Chest Pain, Family History of Cardiomyopathy
Family History of Congenital Heart Defect, Family History of Sudden Death (Under 50 Years)
Genetic Syndrome, Hemoglobinopathies, Hypertension, Kawasaki Disease
Marfan's Syndrome, Muscular Dystrophy, Palpitations, Abnormal ECG
Rule out Pericardial Effusion, Rule out Pulmonary Hypertension, Rule out Vegetation / Clot
Shortness of Breath, Syncope During Exam, Other (please specify) _____

Comments: _____

Please fax legibly completed form and accompanying documentation, including results of tests already completed, to **905-521-5056**. **Incomplete requisitions WILL NOT BE PROCESSED.**
If you have any questions about your requisition, please contact: (905) 521-2100 ext. 73974

Confirmation of Appointment Date and Time will be provided directly to the patient.