


CARDIAC DIAGNOSTICS REQUISITION		Patient Information:	
 Department of Diagnostic Imaging 310 Juliana Drive Woodstock, ON N4V0A4 Phone: 519-421-4204 Fax: 519-421-4241 Central Bookings Phone: 519-537-2381 Fax: 519-421-4238	Name (Last, First): _____ DOB: _____ <input type="checkbox"/> M <input type="checkbox"/> F PIN: _____ <small>MMM DD YYYY</small> Address: _____ Phone Number (Home): _____ (Other): _____ Health Card Number: _____ Version Code: _____		
	Referring Physician or Other Authorized Health Care Provider Name (Please Print): _____ Phone: _____ Fax: _____ <div style="border: 1px solid black; padding: 5px; width: fit-content;"> Ordering Physician or Authorized Health Care Provider Signature: </div> Copy to: _____		Patient Height: _____ feet ' inches " or centimetre (cm) Patient Weight: _____ pounds (lb) or kilograms (kg) <input type="checkbox"/> Patient greater than 300 lb or 136 kg Medications: _____ Relevant Patient History:

CARDIAC EXAMINATION:																																	
<input type="checkbox"/> Echocardiography <input type="checkbox"/> Cardiac Clinic (LHSC Cardiologist only) Date requested: _____ <hr/> Clinical Indications for Echocardiography: <table border="0"> <tr> <td><input type="checkbox"/> Baseline Left Ventricular (LV) function or periodic review when using cardiotoxic drugs (Chemotherapy)</td> <td><input type="checkbox"/> Neurologic or Other Possible Embolic Events</td> </tr> <tr> <td><input type="checkbox"/> Cardiac Mass</td> <td><input type="checkbox"/> Palpitations or Arrhythmia</td> </tr> <tr> <td><input type="checkbox"/> Cardiomyopathy</td> <td><input type="checkbox"/> Pericardial Disease</td> </tr> <tr> <td><input type="checkbox"/> Chest Pain</td> <td><input type="checkbox"/> Pre-Cardioversion</td> </tr> <tr> <td><input type="checkbox"/> Congenital or Inherited Structural Heart Disease</td> <td><input type="checkbox"/> Pre-Pacemaker or Intracardiac Device (ICD)</td> </tr> <tr> <td><input type="checkbox"/> Congestive Heart Failure</td> <td><input type="checkbox"/> Prosthetic Heart Valve: <input type="checkbox"/> Aortic <input type="checkbox"/> Mitral</td> </tr> <tr> <td><input type="checkbox"/> Coronary Artery Disease</td> <td><input type="checkbox"/> Tricuspid <input type="checkbox"/> Pulmonic</td> </tr> <tr> <td><input type="checkbox"/> Dyspnea</td> <td><input type="checkbox"/> Date (year): _____</td> </tr> <tr> <td><input type="checkbox"/> Edema</td> <td><input type="checkbox"/> Pulmonary Disease</td> </tr> <tr> <td><input type="checkbox"/> Heart Murmur</td> <td><input type="checkbox"/> Pulmonary Embolism</td> </tr> <tr> <td><input type="checkbox"/> Hypertension</td> <td><input type="checkbox"/> Suspected Structural Heart Disease</td> </tr> <tr> <td><input type="checkbox"/> Infective Endocarditis</td> <td><input type="checkbox"/> Thoracic Aortic Disease</td> </tr> <tr> <td><input type="checkbox"/> Interventional Procedures</td> <td><input type="checkbox"/> Valvular Regurgitation</td> </tr> <tr> <td><input type="checkbox"/> Known or Suspected Mitral Valve Prolapse</td> <td><input type="checkbox"/> Valvular Stenosis</td> </tr> <tr> <td><input type="checkbox"/> Previous Echocardiography: _____</td> <td><input type="checkbox"/> Other: _____</td> </tr> <tr> <td>Date: _____</td> <td></td> </tr> </table>	<input type="checkbox"/> Baseline Left Ventricular (LV) function or periodic review when using cardiotoxic drugs (Chemotherapy)	<input type="checkbox"/> Neurologic or Other Possible Embolic Events	<input type="checkbox"/> Cardiac Mass	<input type="checkbox"/> Palpitations or Arrhythmia	<input type="checkbox"/> Cardiomyopathy	<input type="checkbox"/> Pericardial Disease	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Pre-Cardioversion	<input type="checkbox"/> Congenital or Inherited Structural Heart Disease	<input type="checkbox"/> Pre-Pacemaker or Intracardiac Device (ICD)	<input type="checkbox"/> Congestive Heart Failure	<input type="checkbox"/> Prosthetic Heart Valve: <input type="checkbox"/> Aortic <input type="checkbox"/> Mitral	<input type="checkbox"/> Coronary Artery Disease	<input type="checkbox"/> Tricuspid <input type="checkbox"/> Pulmonic	<input type="checkbox"/> Dyspnea	<input type="checkbox"/> Date (year): _____	<input type="checkbox"/> Edema	<input type="checkbox"/> Pulmonary Disease	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Pulmonary Embolism	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Suspected Structural Heart Disease	<input type="checkbox"/> Infective Endocarditis	<input type="checkbox"/> Thoracic Aortic Disease	<input type="checkbox"/> Interventional Procedures	<input type="checkbox"/> Valvular Regurgitation	<input type="checkbox"/> Known or Suspected Mitral Valve Prolapse	<input type="checkbox"/> Valvular Stenosis	<input type="checkbox"/> Previous Echocardiography: _____	<input type="checkbox"/> Other: _____	Date: _____		<input type="checkbox"/> Standard Graded Exercise Stress Test *Patient must be able to walk on treadmill* <input type="checkbox"/> Holter Monitor: <input type="checkbox"/> 24 hours <input type="checkbox"/> 48 hours <input type="checkbox"/> 72 hours <input type="checkbox"/> Loop/Event Recorder 2 weeks <input type="checkbox"/> ECG (Electrocardiogram) <hr/> Clinical Indications for Stress, Holter, Loop Recording or ECG: <input type="checkbox"/> Cardiac Rehabilitation <input type="checkbox"/> Chest Pain <input type="checkbox"/> Dizzy Spells <input type="checkbox"/> Functional Capacity <input type="checkbox"/> Pacemaker or Defibrillator <input type="checkbox"/> Palpitations <input type="checkbox"/> Premature Ventricular Contractions (PVC) <input type="checkbox"/> Rule out Atrial Fibrillation <input type="checkbox"/> Post Myocardial Infarction (MI) <input type="checkbox"/> Post Percutaneous Coronary Intervention (PCI) or Coronary Artery Bypass Grafting (CABG) <input type="checkbox"/> Syncope <input type="checkbox"/> Other (specify) _____
<input type="checkbox"/> Baseline Left Ventricular (LV) function or periodic review when using cardiotoxic drugs (Chemotherapy)	<input type="checkbox"/> Neurologic or Other Possible Embolic Events																																
<input type="checkbox"/> Cardiac Mass	<input type="checkbox"/> Palpitations or Arrhythmia																																
<input type="checkbox"/> Cardiomyopathy	<input type="checkbox"/> Pericardial Disease																																
<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Pre-Cardioversion																																
<input type="checkbox"/> Congenital or Inherited Structural Heart Disease	<input type="checkbox"/> Pre-Pacemaker or Intracardiac Device (ICD)																																
<input type="checkbox"/> Congestive Heart Failure	<input type="checkbox"/> Prosthetic Heart Valve: <input type="checkbox"/> Aortic <input type="checkbox"/> Mitral																																
<input type="checkbox"/> Coronary Artery Disease	<input type="checkbox"/> Tricuspid <input type="checkbox"/> Pulmonic																																
<input type="checkbox"/> Dyspnea	<input type="checkbox"/> Date (year): _____																																
<input type="checkbox"/> Edema	<input type="checkbox"/> Pulmonary Disease																																
<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Pulmonary Embolism																																
<input type="checkbox"/> Hypertension	<input type="checkbox"/> Suspected Structural Heart Disease																																
<input type="checkbox"/> Infective Endocarditis	<input type="checkbox"/> Thoracic Aortic Disease																																
<input type="checkbox"/> Interventional Procedures	<input type="checkbox"/> Valvular Regurgitation																																
<input type="checkbox"/> Known or Suspected Mitral Valve Prolapse	<input type="checkbox"/> Valvular Stenosis																																
<input type="checkbox"/> Previous Echocardiography: _____	<input type="checkbox"/> Other: _____																																
Date: _____																																	
Appointment Date:	Appointment Time:																																

BOOKINGS CANNOT BE MADE UNLESS REQUISITION IS COMPLETED IN FULL
 Please submit completed requisition by fax to Central Bookings: 519-421-4238
PLEASE BRING THIS REQUISITION AND YOUR HEALTH CARD
 To cancel or reschedule your appointment please call Central Bookings: 519-537-2381



PREPARATION for ALL CARDIAC DIAGNOSTIC PROCEDURES

- No restrictions on food or drinks or medications (unless instructed by your Physician)
- Bring a list of current medications
- Please arrive 20 minutes before your appointment time. Check in on the Main Floor Diagnostic Imaging, Cardio-Respiratory Reception. Late arrivals may be rebooked

EXAM	EXAM DESCRIPTION	DURATION
Echocardiogram (ECHO)	An echocardiogram is an ultrasound study of the heart. It evaluates the chambers for function, the walls and chambers for size and heart valves to check the blood flow. You will be lying on your left side for the majority of the exam. Results will be relayed to your Health Care Provider after being interpreted by a Physician.	45-60 minutes
Electrocardiogram (ECG)	An electrocardiogram (ECG) is a test that measures the electrical activity of the heart. It involves the placement of electrodes which are small adhesive patches or suction cups that are placed on your chest, arms and legs. There are sensor pads in these patches that record the electrical activity which is recorded, then interpreted by a Physician.	15-20 minutes
Standard Graded Exercise Test *Patient must be able to walk on treadmill	The Standard Exercise Stress Test is a general screening tool used to evaluate the heart's response to graded exercise. At predetermined intervals the exercise will increase and the patient's ECG, blood pressure and heart rate are recorded. The results of the test may help your physician decide if you have heart disease, and if so, how severe it is.	30-45 minutes
Holter Monitor	Holter monitoring enables your Physician to find out how well your heart is keeping its rhythm as you go about your day-to-day activities. Since the monitor continuously records your heart beat over the period of time you wear it, <u>it is suggested that you bathe prior to your first exam visit</u> , as you won't be able to shower or bathe while wearing the monitor. It records on a small digital recorder for subsequent review and analysis.	20-30 minutes
Loop or Event Monitor	A loop monitor is used to record and evaluate infrequent cardiac irregularities. It is usually worn over a period of 2 weeks with the ability to capture data automatically and/ or patient-activated. This monitor does not record continuously. The simplicity of this monitor allows the patient to remove and bathe and replace sensors.	20-30 minutes

PLEASE CONTACT YOUR ATTENDING PHYSICIAN FOR ANY QUESTIONS REGARDING YOUR MEDICATIONS

To cancel or reschedule your appointment please call Central Bookings: 519-537-2381
 For any questions regarding your Echocardiogram please call: 519-421-4233 extension 2060
 For any questions regarding all other Cardiac Exams please call: 519-421-4233 extension 3160

Please be aware that this is a "Fragrance Free" facility

For more information on these procedures, please visit:

Cardiac Care Network

http://ccn.on.ca/ccn_public/FormsPatientPortal/CommonTestsForYourHeart.aspx

Heart and Stroke Foundation

http://www.heartandstroke.on.ca/site/c.pvl3leNWJwE/b.3581677/k.6103/Heart_Disease_Tests.htm

See My Heart

<http://www.seemyheart.org/>