Kingston Health Sciences Centre
Centre des sciences de la santé de Kingston

Hôpital Hotel Dieu Hospital

KGH Hôpital Général de Kingston General Hospital

Name:
Date of Birth:
CR Number:
Telephone number:

KHSCEcho@kingstonhsc.ca Fax 613-548-1387 Ext 3980

Transthoracic, Stress, and Pediatric/Fetal Echocardiogram Order Form

Date: _____

Type of Test:

- ☐ **Transthoracic Echocardiogram**
- ☐ **Treadmill Stress Echocardiogram**
- ☐ **Bicycle Stress Echocardiogram**
- ☐ **Dobutamine Stress Echocardiogram**
- ☐ **Pediatric Echocardiogram**
- ☐ **Fetal Echocardiogram**

FOR ADULT TRANSTHORACIC OR PEDIATRIC ECHOCARDIOGRAMS: CHOOSE ALL THAT APPLY

- ☐ **LV function**
- ☐ **Native valve disease**
- ☐ **Cardiac Source of embolus**
- ☐ **Pericardial disease**
- ☐ **Bubble study**
- ☐ **Oncology LV assessment**
- ☐ **Murmur**
- ☐ **Prosthetic Valve function**
- ☐ **Congenital heart disease (please specify): _____**
- ☐ **Other (please specify) : _____**
- ☐ **RV function**
- ☐ **Endocarditis**
- ☐ **Pulmonary hypertension**

Relevant Clinical History (include type/size of prosthetic valve if applicable):

_____

FOR STRESS ECHOCARDIOGRAMS ONLY – PLEASE CHOOSE INDICATION

- ☐ **Ischemia**
- ☐ **Low dose dobutamine for assessment of aortic stenosis**
- ☐ **Viability**
- ☐ **Assessment of pulmonary hypertension with exercise**
- ☐ **Assessment of mitral valve disease**
- ☐ **Other (Please specify): _____**

Relevant Clinical History: _____

FOR FETAL ECHOCARDIOGRAMS ONLY – PLEASE PROVIDE INDICATION AND CLINICAL HISTORY

_____

_____

Ordering Physician Name: _____ Signature: _____

Attending Name (Please print) : _____ Contact Number: _____

INCOMPLETE REQUISITIONS WILL BE RETURNED.

FOR ECHO LAB USE ONLY: FOR STRESS ECHO APPROVAL

Approved by: _____ Date: _____