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

Hôpital Hotel Dieu Hospital

KGH Hôpital Général de Kingston General Hospital

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Fax: 613-548-1387

Ext 3980

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

Trans-esophageal Echocardiogram Order Form

Date: _____

Indication: Choose one:

□ **Endocarditis** □ **Cardiac Source of embolus** □ **Native valve disease**

□ **Prosthetic valve disease** □ **Shunt** □ **Pre-ablation**

□ **Other (please specify) : _____**

Relevant clinical history (include type and size of prosthetic valve if applicable):

_____

Is there a previous transthoracic study and/or TEE? If so, please attach previous reports.

Required Information: Does the patient have:

History of esophageal surgery/injury/stricture: Yes □ No □
History of difficulty swallowing: Yes □ No □
History of cirrhosis/esophageal or gastric varices: Yes □ No □
Recent upper GI bleed: Yes □ No □
Previous upper endoscopy: Yes □ No □
If yes, were there any abnormalities in the esophagus: _____
Are there any respiratory concerns for sedation: Yes □ No □
If yes, please specify: _____
History of IV drug use: Yes □ No □
Is the patient on anticoagulants? Yes □ No □
If warfarin, most recent INR: _____ Date of test: _____
Can the patient provide informed consent: Yes □ No □
If no, a substitute decision maker must come with the patient to the appointment.

If this test is urgent, the ordering physician must speak directly to the Echocardiographer (613-549-6666 ext 3980).

Ordering Physician Name: _____ Signature: _____

Attending Name (please print): _____ Contact number: _____

INCOMPLETE REQUISITIONS WILL BE RETURNED.

FOR ECHO LAB USE ONLY:

Approved by: _____ Date: _____