



ROSS MEMORIAL
HOSPITAL
Kawartha Lakes

ECHOCARDIOGRAPHY DEPARTMENT

(Ultrasound of the Heart)

Booking Line (705) 328-6186

Fax Line (705) 328-6188

***** OUR DEPARTMENT WILL NEED YOUR
ONTARIO HEALTH CARD*****

Exam may take up to 1 hour
No Preparation required

DO NOT WRITE IN THIS AREA - FOR RMH USE ONLY

EXAM #

PATIENT NAME: _____

HEALTH CARD # _____

DOB: _____

TELEPHONE: _____

ADDRESS: _____

REFERRING DOCTOR: _____

FAMILY DOCTOR: _____

CC DOCTOR: _____

- Urgent ER/IP
- < 7 days
- > 7 days
- Discharged
- Admitted Rm # _____
Extension _____

****NON-AMBULATORY PATIENTS MUST
ARRIVE ON A STRETCHER****

ISOLATION PRECAUTIONS - MUST BE COMPLETED

- Not Required Airborne Droplet
- Contact C Difficile
- AND YES NO

Relevant Medical History:

- | | | |
|---|-------------------------------------|---------------------------------------|
| <input type="checkbox"/> Post MI | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Post PCI | <input type="checkbox"/> TIA/Stroke | <input type="checkbox"/> Palpitations |
| <input type="checkbox"/> Endocarditis | <input type="checkbox"/> Syncope | <input type="checkbox"/> SOB |
| <input type="checkbox"/> Pulmonary Embolism | <input type="checkbox"/> AFib | |
| <input type="checkbox"/> Pericardial Effusion | <input type="checkbox"/> Murmur | |

Bioprosthetic Valve replacement --> Valve Name _____

Mechanical Valve replacement --> Valve Name _____

Other _____

PHYSICIAN'S SIGNATURE: _____

(Must be ordered & signed by a physician)

Nurse Verified: _____

Chart Order Medical Directive

DATE: _____

PPE Worn: Face Shield Goggles
 Gown Gloves Mask N95 Mask

Appointment Date	Time	Medical Record #
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INCOMPLETE AND/OR UNSIGNED REQUISITIONS WILL BE RETURNED