



# BC'S ECHOCARDIOGRAM REQUISITION

DIXX105936A

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- Outpatient
- Standard (TTE)
- TEE
- Intra-op TEE
- Definity contrast
- Stress
- Saline bubble
- Inpatient - Unit/Ward \_\_\_\_\_

Surname	First Name	Sex <input type="checkbox"/> <input type="checkbox"/>
Address		
City	Home Phone	
Date of Birth (dd/mm/yy)	Work Phone	
Medical Plan Number	WCB / ICBC Claim Number	
<input type="checkbox"/> MSP <input type="checkbox"/> WCB <input type="checkbox"/> ICBC <input type="checkbox"/> PATIENT <input type="checkbox"/> OTHER		

**APPOINTMENT:**  
 Date Requisition received \_\_\_\_\_  
 Ordered Date: \_\_\_\_\_ month/day/year Time: \_\_\_\_\_  
 Booked Date: \_\_\_\_\_ month/day/year Time: \_\_\_\_\_  
 Completed Date: \_\_\_\_\_ month/day/year Time: \_\_\_\_\_

Emergent (within 24 hours) (for outpatients call physician on-call or Echo department)  
 Urgent/Semi-urgent (7 days)  
 Scheduled/Non-urgent (30 days)  
 Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
 Latex allergy:  No  Yes  
 Infections: \_\_\_\_\_  
 (e.g VRE / MRSA / C-Diff/TB)

**\* REQUESTS WITHOUT CLINICAL INFORMATION WILL BE RETURNED \***

**IDENTIFY:** Patient History, Pertinent Clinical Information and reason(s) for ordering Echo

✓ CHECK ALL THAT APPLY

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Murmur<br><input type="checkbox"/> systolic<br><input type="checkbox"/> diastolic<br><input type="checkbox"/> Aortic<br><input type="checkbox"/> stenosis<br><input type="checkbox"/> regurgitation<br><input type="checkbox"/> bicuspid<br><input type="checkbox"/> Mitral<br><input type="checkbox"/> stenosis<br><input type="checkbox"/> regurgitation<br><input type="checkbox"/> prolapse<br><input type="checkbox"/> repair<br><input type="checkbox"/> Pulmonary<br><input type="checkbox"/> stenosis<br><input type="checkbox"/> regurgitation<br><input type="checkbox"/> Tricuspid<br><input type="checkbox"/> stenosis<br><input type="checkbox"/> regurgitation | <input type="checkbox"/> Cardiomyopathy<br><input type="checkbox"/> dilated<br><input type="checkbox"/> hypertrophic<br><input type="checkbox"/> restrictive<br><input type="checkbox"/> Pulmonary Hypertension<br><input type="checkbox"/> Systemic Hypertension<br><input type="checkbox"/> Left Ventricular Hypertrophy<br><input type="checkbox"/> Right Ventricular Function<br><input type="checkbox"/> Heart Failure<br><input type="checkbox"/> Transplant: type _____<br><input type="checkbox"/> Left Ventricular Function<br>Previous EF _____% (if known)<br>Date: _____<br><input type="checkbox"/> Diastolic Function | <input type="checkbox"/> Myocardial Infarction Date: _____<br><input type="checkbox"/> Anterior <input type="checkbox"/> Inferior <input type="checkbox"/> Unknown<br><input type="checkbox"/> Coronary Artery Bypass Graft<br>Date: _____<br><input type="checkbox"/> Dysrhythmia<br><input type="checkbox"/> Atrial fibrillation <input type="checkbox"/> Other _____<br><input type="checkbox"/> Source of embolus<br>Other Indications:<br><input type="checkbox"/> Trauma <input type="checkbox"/> Chemotherapy<br><input type="checkbox"/> CAD <input type="checkbox"/> Pericardial disease<br><input type="checkbox"/> Pregnant <input type="checkbox"/> Aortic aneurysm<br><input type="checkbox"/> Infective endocarditis<br><input type="checkbox"/> Pericardial effusion<br>Symptoms<br><input type="checkbox"/> Short of breath <input type="checkbox"/> Syncope<br><input type="checkbox"/> Chest pain <input type="checkbox"/> Palpitations<br><input type="checkbox"/> Fatigue <input type="checkbox"/> Other _____ |
|---|---|--|

Prosthesis	Type/Manufacturer	Size	Date Implanted
Aortic			
Mitral			
Tricuspid			

Congenital Defect: (attach operative report)

Other History:

Attending Physician Printed name \_\_\_\_\_ Signature \_\_\_\_\_  
 MSC # \_\_\_\_\_ Phone # \_\_\_\_\_ Pager # \_\_\_\_\_  
 Copies to: \_\_\_\_\_  Preliminary report with patient

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# BC ECHOCARDIOGRAM REQUISITION

## Cont'd

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### BENCHMARK WAIT TIMES FOR ACCESSING ECHOCARDIOGRAPHY

Urgency Category	Recommended wait time	Defined by: Examples
Emergent	Within 24 hours	Hemodynamically unstable patients with suspected certain cardiovascular conditions (e.g. pericardial effusion with tamponade, mechanical complications, post myocardial infarction)
Urgent/Semi urgent	Within 7 days	Critically ill patients who do not meet the definition of emergent and patients with a condition that could deteriorate rapidly (e.g. symptomatic aortic stenosis)
Scheduled/Non urgent	Within 30 days	All patients who do not fall into the previous categories (e.g. assessment of murmurs in asymptomatic individuals, assessment of left ventricle mass)

Adapted from: 2008, CCS Wait time benchmarks: *Treating the Right Patient at the Right Time: Access to Echocardiography in Canada*

**\* INCOMPLETE REQUISITION FORMS WILL BE RETURNED \***

Site	Address	Phone	Fax
VGH	Diamond Healthcare Building, Ground floor 2775 Laurel St, Vancouver	604-875-4800	604-875-5827
SPH	Providence Building, 2nd floor 1081 Burrard Street Vancouver, BC	604-806-8018	604-806-8410
MSJ	Main Building, Floor 3A 3080 Prince Edward Street, Vancouver, BC	604-877-8190	604-806-8410
UBCH	Koerner Pavillion, 2nd floor 2211 Wesbrook Mall, Vancouver, BC	604-822-7190	604-822-1711
RH	Main Building, Main Floor (Yellow Zone) 7000 Westminster Highway, Richmond, BC	604-244-5104	604-244-5232
LGH	Main Building, Basement Floor (Radiology Dept) 231 East 15th Street, North Vancouver	604-984-5721	604-984-5716
Sechelt (SMH)	Main Building, Main Floor (Imaging Dept) 5544 Sunshine Coast Highway, Sechelt, BC	604-885-8608	604-885-8652
Powell River	Main building, Main Floor (X-Ray Dept) 5000 Joyce Avenue, Powell River, BC	1-604-485-3282	1-604-485-3254

### IMPORTANT PATIENT INFORMATION

- Plan to arrive 15 minutes early to give yourself adequate time for parking.
- An interpreter must accompany patients who do not speak fluent English or the exam may be cancelled.
- Children and other third parties are not permitted in the examination rooms. Please ensure that children under the age of 12 have someone to look after them during your exam or we will not be able to do your exam.
- **\*\*Please bring your Care Card, WorkSafe BC or ICBC information and Photo Identification\*\***