HEADWATERS
Health Care Centre

**Patient Name (REQUIRED)** _____

Date of Birth _____

Address _____

Phone # _____ HC# _____

## DIAGNOSTIC IMAGING REQUISITION

100 Rolling Hills Drive, Orangeville ON L9W 4X9
Phone: 519-941-2410 Fax: 519-941-7726
**Mon-Fri** 7:00 am - 7:45 pm
**Sat-Sun** 8:00 am - 12:00 pm & 12:45 pm – 3:45 pm

**Follow up in ER** □Yes □ No

**Without this SIGNED requisition your exam CANNOT be performed. Please bring your Ontario Health Card. Please arrive 15 minutes prior to exam time. Late patients may be required to reschedule exam. INCOMPLETE REQUESTS WILL BE RETURNED, RESULTING IN A DELAY OF BOOKING**

# ECHOCARDIOGRAPHY (Appointment required)

### INDICATION (SELECT AT LEAST ONE)

- ☐ Heart Murmurs
- ☐ Native Valvular Stenosis
- ☐ Native Valvular Regurgitation
- ☐ Known or Suspected Mitral Valve Prolapse
- ☐ Congenital or inherited Cardiac Structural Disease (including Bicuspid Aortic Valve, Marfan's Syndrome, Atrial Septal Defect, Ventricular Septal Defect, Ehler's Danlos Syndrome)
- ☐ Prosthetic Heart Valves
- ☐ Infective Endocarditis
- ☐ Pericardial Disease
- ☐ Cardiac Masses
- ☐ Interventional Procedures
- ☐ Pulmonary Diseases
- ☐ Chest Pain and Coronary Artery Disease
- ☐ Dyspnea, Edema and Cardiomyopathy
- ☐ Hypertension
- ☐ Thoracic Aortic Disease
- ☐ Neurologic or other Possible Embolic Events
- ☐ Arrhythmias Syncope and Palpitations
- ☐ Before Cardioversion
- ☐ Suspected Structural Heart Disease
- ☐ Others: _____

## CLINICAL INFORMATION (REQUIRED):

**Ordering (print):**_____

**(Signature)**:_____ Date: _____ C.C._____

**Office Phone (REQUIRED) #:**_____ ☐ **Verbal / Fax** _____

***"We do our best to keep on time, but urgent and emergency patients take priority."***
**Children whose parents are having an examination WILL NOT be allowed into the exam room**
**PLEASE MAKE THE NECESSARY BABYSITTING ARRANGEMENTS.**
***For more information, please visit us online at www.headwatershealth.ca***