SOUTH BRUCE GREY HEALTH CENTRE
CHESLEY | DURHAM | KINCARDINE | WALKERTON

SBGHC ECHOCARDIOGRAPHY/ECG TEST REQUISITION

FOR AN APPOINTMENT PLEASE PHONE OR FAX:

Kincardine Phone 519-396-3331 Fax 519-396-1478 Walkerton Phone 519-881-1220 Fax 519-881-1388

DATE OF REFERRAL: (yyyy/mm/dd)		
PATIENT NAME:		
ADDRESS:		TEL: Home:
CITY:	POSTAL CODE:	Business:
D.O.B.: (yy/mm/dd)	HEALTH CARD #:	

REFERRING PHYSICIAN:

NAME:	
TELEPHONE:	FAX:

TEST REQUESTED:

☐ ECHOCARDIOGRAM ☐ ECG

☐ Kincardine ☐ Walkerton

Has patient undergone cardiac testing in the past 6 months? ☐ YES ☐ NO

Details:

REASON FOR REQUESTED STUDIES: (MUST BE COMPLETED IN FULL)

☐ LV DYSFUNCTION/CAD	☐ PRIOR M.I.	☐ CHEST PAIN
☐ SYNCOPE	☐ CABG	☐ PULMONARY HYPERTENSION
☐ CARDIOMYOPATHY	☐ DYSPNEA	☐ FAMILY HX OF HEART DISEASE
☐ VALVE REPLACEMENT	☐ HYPERTENSION/LVH	☐ ABNORMAL ECG
☐ CONGENITAL	☐ CHEMOTHERAPY	☐ PERICARDIAL DISEASE

☐ MURMUR:_____ ☐ VALVE DISEASE:_____

☐ ARRYTHMIA/PALPITATIONS ☐ CVA/TIA/SOURCE OF EMBOLUS

RELEVANT CLINICAL INFORMATION:

Physician Signature: _____

CPSO #: _____

Scheduled Date: ____/____/____ **Time:** _____
yyyy mm dd