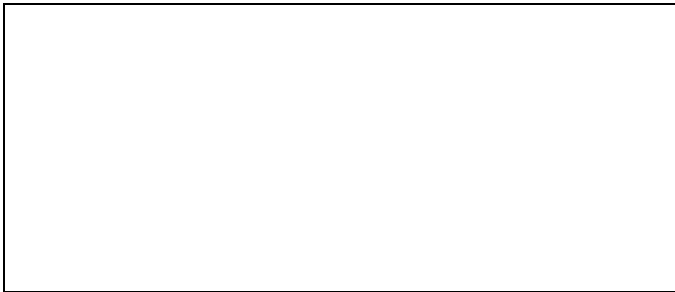




Thunder Bay Regional
Health Sciences
Centre

Cardio/Respiratory
Diagnostic Testing

**REFERRAL REQUISITION
ECHOCARDIOGRAPHY**



Cardio/Respiratory Bookings Office:
Telephone: 807-684-6680 / Fax: 807-684-5907

Guidelines:

1. Physicians must complete and sign requisitions. Signature stamps are prohibited. Incomplete requisitions will be returned resulting in delay of study.
2. Fax requisition to (807) 684-5907. Completed requisitions will be filed in the booking office.
3. Patients should be given the appropriate test information sheet available online at <http://tbrhsc.net/programs-services/diagnostic-services/cardio-respiratory-services/>

Referring MD: _____

Family MD: _____

IN-PT only - Does patient require a Cardiology consult? No Yes

Indication for Test (required – see reverse for list of indications and state #): _____

ECHOCARDIOGRAM

- Complete
- Limited Specify: _____
- Complete with contrast
- Limited with contrast Specify: _____

STRESS ECHOCARDIOGRAM

- Stress Echo
- Stress Echo with contrast
- Dobutamine Stress Echo
- Dobutamine Stress Echo with contrast

TRANSESOPHAGEAL ECHOCARDIOGRAM (TEE) Has patient had a transthoracic echocardiogram within 3 months? Yes No

Study Urgency:

- Emergent inpatient (contact Cardiologist on call)
- Urgent inpatient (contact Cardiologist on call)
- Urgent outpatient (10 days)
- Elective outpatient

Indication for TEE (check all that apply):

- Infective Endocarditis
 - Vegetation seen or suspected on TTE
 - Suspected complication
 - Evaluation of prosthetic valve
 - High clinical suspicion
- Evaluation of prosthetic valve. (specify): _____
- Evaluation of valve pathology (specify): _____
- Evaluation for source of embolus with no identified non-cardiac source
- Atrial fibrillation or flutter – assessment for clot prior to cardioversion
- Assessment of shunt (specify): _____
- Assessment of congenital heart disease (specify): _____
- Assessment of aortic pathology (specify): _____

Note: TEE is **not indicated for the following as per ASE guidelines:**

- Routine use of TEE when a diagnostic TTE is reasonably anticipated to resolve all diagnostic and management concerns.
- Surveillance of prior TEE finding for interval change (e.g., resolution of thrombus after anticoagulation, resolution of vegetation after antibiotic therapy) when no change in therapy is anticipated.
- Routine assessment of pulmonary veins in an asymptomatic patient status post pulmonary vein isolation.
- To diagnose infective endocarditis with a low pretest probability (e.g., transient fever, known alternative source of infection, or negative blood cultures/atypical pathogen for endocarditis).
- Evaluation for cardiovascular source of embolus with a previously identified non-cardiac source.
- Atrial fibrillation/flutter: evaluation when a decision has been made to anticoagulate and not to perform cardioversion.

Physician's Name: _____

(please print)

Physician's Signature: _____

Date: _____

CHEST PAIN AND CORONARY ARTERY DISEASE

- 1.1 Chest pain with hemodynamic instability
- 1.2 Chest pain suggestive of underlying coronary artery disease
- 1.3 Murmur associated with acute or recent myocardial infarction
- 1.4 Assessment of LV function post myocardial infarction
- 1.5 Assessment of LV function post PCI or CABG
- 1.6 Evaluation of suspected aortic dissection

DYSPNEA, EDEMA and CARDIOMYOPATHY

- 2.1 Assessment of patients with suspected heart failure
- 2.2 Clinically suspected cardiomyopathy
- 2.3 Reassess LV function with known cardiomyopathy and clinical change
- 2.4 Screening of relatives for genetically inherited cardiomyopathy
- 2.5 Baseline assessment of LV function before cardiotoxic medical therapy
- 2.6 Reassess LV function on cardiotoxic medical therapy (<6months=LIMITED)

HYPERTENSION

- 3.1 Suspected left ventricular dysfunction
- 3.2 Evaluation for left ventricular hypertrophy that may influence management

NEUROLOGIC OR OTHER POSSIBLE EMBOLIC EVENTS

- 4.1 Stroke or TIA in the absence of established causative pathology
- 4.2 Known occlusion of a major peripheral or visceral artery

ARRHYTHMIAS, SYNCOPE AND PALPITATIONS

- 5.1 Initial investigation of symptomatic arrhythmia
- 5.2 New onset of atrial fibrillation or atrial flutter
- 5.3 Documented frequent PVC's, sustained VT or nonsustained VT
- 5.4 Investigation of syncope of undetermined etiology
- 5.5 Investigation of documented LBBB or high grade AV block
- 5.6 Investigation of patients with WPW pre-excitation.

PULMONARY DISEASES

- 6.1 Clinically suspected undiagnosed pulmonary hypertension
- 6.2 Reassess pulmonary hypertension /evaluate treatment response (LIMITED)
- 6.3 Clinically suspected acute pulmonary embolism
- 6.4 Follow-up treatment for known pulmonary embolism
- 6.5 Known chronic lung disease-Rule out cardiac involvement

CONGENITAL STRUCTURAL CARDIAC DISEASE

- 7.1 Known congenital structural heart disease and clinical change
- 7.2 Family history / screening for inherited cardiac structural disease
- 7.3 Reassessment (≥ 2 yrs) of asymptomatic individuals with previously diagnosed congenital or inherited cardiac structural disease

SUSPECTED STRUCTURAL HEART DISEASE

- 8.1 Where an investigation suggests possible structural heart disease and an echocardiographic study has not been previously performed or the finding has not been previously identified

INTERVENTIONAL PROCEDURES

- 9.1 To assist in pre-procedural decision making
- 9.2 Post-intervention baseline study (< 3 months post procedure)
- 9.3 Re-evaluation post intervention and clinical change

HEART MURMUR

- 10.1 New murmur - asymptomatic patient, rule out structural heart disease
- 10.2 Undiagnosed murmur heard in patient with cardiorespiratory symptoms
- 10.3 Re-evaluation of known murmur with change in clinical status

VALVULAR STENOSIS (Valve Must Be Documented)

- 11.1 Clinical suspicion of undiagnosed valvular stenosis
- 11.2 Reassessment (>2yr) of mild stenosis without clinical change
- 11.3 Reassessment (>1yr) of moderate stenosis without clinical change
- 11.4 Reassessment (>6months) of severe stenosis without clinical change
- 11.5 Known valvular stenosis (any degree) with significant clinical change

VALVULAR REGURGITATION (Valve Must Be Documented)

- 12.1 Clinical suspicion of undiagnosed valvular regurgitation
- 12.2 Reassessment (>2yr) of asymptomatic mild valvular regurgitation
- 12.3 Reassessment (>1yr) of asymptomatic moderate valvular regurgitation
- 12.4 Reassessment (>6months) of asymptomatic severe valvular regurgitation
- 12.5 Known valvular regurgitation (any degree) with significant clinical change

MITRAL VALVE PROLAPSE

- 13.1 Clinical suspicion of undiagnosed mitral valve prolapse
- 13.2 Re-evaluate due to clinical suspicion of progressive valvular dysfunction
- 13.3 Reassessment (>1yr) moderate/severe leaflet thickening or redundancy

INFECTIVE ENDOCARDITIS

- 14.1 Clinical suspicion of undiagnosed endocarditis
- 14.2 Reassessment for disease progression while receiving medical therapy

PROSTHETIC AND REPAIRED HEART VALVES (Sx Details Must Be Documented)

- 15.1 Assessment of newly implanted/repai red heart valve – Baseline Study
- 15.2 Reassessment (>1yr) if patient hemodynamically stable and asymptomatic
- 15.3 Reassessment (<1yr) if significant change in clinical status

THORACIC AORTIC DISEASE

- 16.1 Suspected dilation of ascending aorta
- 16.2 Reassessment(>2yr) of asymptomatic dilation <42.5mm
- 16.3 Reassessment(>1yr) of asymptomatic dilation 42.5mm-50mm
- 16.4 Reassessment(>6months) of asymptomatic dilation >50mm
- 16.5 Known aortic dilation with significant rate of growth or clinical change
- 16.6 Known Marfan Syndrome or other connective tissue disorder
- 16.7 Clinically suspected aortic dissection

PERICARDIAL DISEASE

- 17.1 Suspected pericarditis, pericardial effusion, tamponade or constriction
- 17.2 Follow-up of pericardial disease of suspected clinical significance
- 17.3 Yearly follow-up of moderate or severe pericardial effusion
- 17.4 Echo guided pericardiocentesis for diagnostic or therapeutic purposes

CARDIAC MASSES

- 18.1 Clinical syndromes suspicious for an underlying cardiac mass
- 18.2 Follow up post surgical removal of mass/tumor
- 18.3 Patients with malignancies and echo needed for disease staging process
- 18.4 Evaluation of cardiac mass detected by other imaging modalities