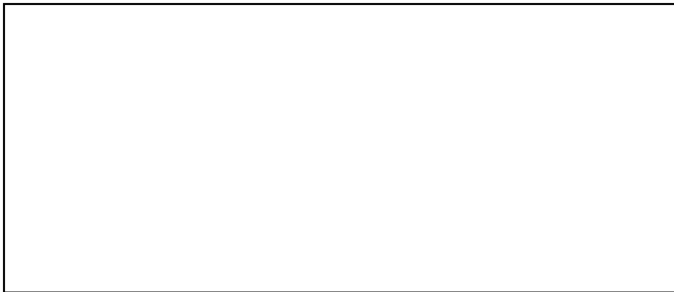
Cardio/Respiratory
Diagnostic Testing

REFERRAL REQUISITION
ECHOCARDIOGRAPHY



Cardio/Respiratory Bookings Office:
Regular Echo and TEE – Telephone: 807-684-6680 / Fax: 807-684-5907
Stress Echo – Telephone: 807-684-6322 / Fax: 807-684-5907
Regional Bookings – Telephone: 1-877-257-6777 / 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 #): ____________

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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/repaired 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