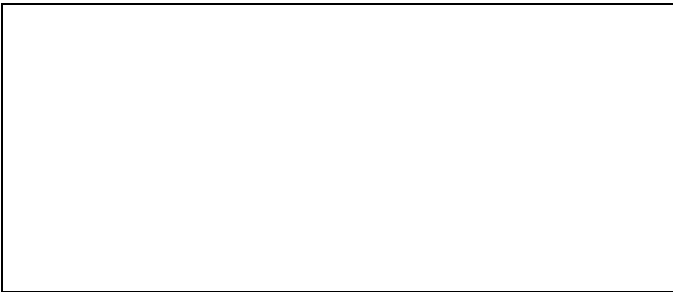




Thunder Bay Regional
Health Sciences
Centre

Cardiac Diagnostics

REFERRAL REQUISITION ECHOCARDIOGRAPHY



Cardiac Diagnostics Bookings Office:

Regular Echo and TEE – Telephone: 807-684-6680

Stress Echo – Telephone: 807-684-6322

Regional Bookings – Telephone: 1-877-257-6777

Guidelines:

1. Physicians must complete and sign requisitions. Signature stamps are prohibited. Incomplete requisitions will be returned resulting in delay of study.
2. Fax Regional requisitions including Regional referrals to Diagnostic Imaging Central Intake **855-978-1862**.
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): _____

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 for TEE only:

- 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