ECHOCARDIOGRAM REFERRAL FORM

(PLEASE COMPLETE AND FAX TO 758-3211)

PATIENT: ____ DOB: _______________

REFERRING PHYSICAN: ____

PHONE#: ______________________________ FAX#: _______________________________

STUDY TYPE: ❑ 2-D ECHO ❑ STRESS ❑ BUBBLE CALL REPORT: ❑ YES ❑ NO

DIAGNOSIS: (PLEASE CHECK AT LEAST ONE)

- ❑ AORTIC VALVE DISORDERS
- ❑ AORTIC VALVE REPLACEMENT
- ❑ ATRIAL FIBRILLATION
- ❑ CARDIAC ARREST
- ❑ CARDIOMEGALY / LVH
- ❑ CARDIOMYOPATHY
- ❑ CHEST PAIN
- ❑ CONGENITAL HEART DISEASE
- ❑ CONGESTIVE HEART FAILURE
- ❑ CORONARY ARTERY DISEASE
- ❑ CVA / STROKE
- ❑ AORTIC DISSECTION
- ❑ ENDOCARDITIS
- ❑ FEVER
- ❑ HEART MURMUR
- ❑ MALFUNCTIONING PROSTHETIC VALVE
- ❑ MITRAL VALVE DISORDERS
- ❑ MITRAL VALVE REPLACEMENT
- ❑ MYOCARDIAL INFARCT
- ❑ ORTHOPNEA
- ❑ PERICARDITIS
- ❑ PULMONARY EDEMA
- ❑ PULMONARY HYPERTENSION
- ❑ PULMONARY EMBOLUS
- ❑ RHEUMATIC HEART DISEASE
- ❑ SHOCK
- ❑ SHORTNESS OF BREATH
- ❑ SUPRAVENTRICULAR TACHYCARDIA
- ❑ SYNCOPE
- ❑ TRANSIENT ISCHEMIC ATTACK
- ❑ TRICUSPID VALVE DISORDER
- ❑ VENTRICULAR TACHYCARDIA

ADDITIONAL DIAGNOSES: (STRESS ECHO ONLY)

❑ ABNORMAL ECG ❑ ARRHYTHMIA ❑ PRE-OP CARDIOVASCULAR EVALUATION

CONTACT/COMMENTS: ____

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