Health PEI
One Island Health System

Queen Elizabeth Hospital
Ph: (902) 894-0067 Scheduling
Fax: (902) 894-2457

Prince County Hospital
Ph: (902) 894-0067 Scheduling
Fax: (902) 894-2457

ECHOCARDIOGRAM REQUEST

PATIENT INFORMATION

Health Care # _____ DOB: yyyy/mm/dd _____

Surname _____ First Name _____ Middle _____

Address _____

City _____ Postal Code _____

Tel _____ Cell _____

PRIORTY (Mandatory)**:**

- ☐ URGENT
- ☐ SEMI-URGENT
- ☐ ELECTIVE

PATIENTS

WEIGHT _____

HEIGHT _____

AMBULATORY

☐ YES ☐ NO

EXAMINATION REQUESTED

TRANSTHORACIC ECHO (TTE)

- ☐ FULL STUDY ☐ LV CONTRAST ☐ BUBBLE STUDY
- ☐ LIMITED STUDY (SPECIFY BELOW)

_____

TRANSESOPHAGEAL ECHO (TEE)

☐ TEE ***COMPLETE REVERSE SIDE FOR TEE***

_____

STRESS ECHO

☐ DOBUTAMINE ECHO (see check list below)
- ☐ Pt able to consent
- ☐ Current or recent ACS
- ☐ Current or recent Ventricular arrhythmia

☐ EXERCISE ECHO (see check list below)
Patient able to walk on treadmill
☐ YES ☐ NO

CLINICAL HISTORY AND PROVISIONAL DIAGNOSIS:

REQUESTING PHYSICIAN/NP INFORMATION: CONTACT INFO OF REQUESTING DR./NP IS REQUIRED

Physician/NP Name (Print): _____ **Physician/NP Signature:** _____

Phone Number (Cell): _____ **Fax Number:** _____

Extra Report to: _____ **Date:** _____

QUEEN ELIZABETH HOSPITAL
QEH
PRINCE EDWARD ISLAND
A division of Health PEI

Dr. Joseph A. Eileen McMillan Ambulatory Care Centre

Transesophageal Echocardiogram (TEE) PRE-PROCEDURE CHECKLIST

Place Patient Label Here

Name:_____
Last **First** **Initial**

MRN:_____ **DOB**_____
(yyyy/ MMM/ dd)

Please complete this checklist ☑ *Indicates completed*

This is to be completed by the referring healthcare professional.

Return by fax (902) 894-2457 to the Echo Department with Diagnostic Imaging requisition.

The procedure will NOT be booked unless this form is completed and returned.

Weight: _____	Mobility Limitations _____	
☐ Preprinted TEE orders signed on the patient's chart		
☐ Is the patient able to give consent? ☐ Yes ☐ No If not, what are the consent issues? _____		
☐ Allergies: List:	☐ Smoker ☐ Alcohol/week _____	☐ Diabetic ☐ Insulin reduced
☐ Is the patient on Coumadin? If so, recent INR result _____ Date_____		
☐ Any difficulty swallowing or choking on foods/liquids ☐ Yes ☐ No		
☐ Is there a history of esophageal disease eg. varices, strictures, radiation? ☐ Yes ☐ No		
☐ Is a gastric feeding tube in place? ☐ Yes ☐ No		
☐ Is the patient able to turn to left side? ☐ Yes ☐ No		
☐ Current vital signs? BP_____ HR_____		
☐ Does the patient maintain 0_2 saturation >92% on room air? ☐ Yes ☐ No ☐ Hx OSA		
☐ Does the patient require oxygen? ☐ Yes, How much?_____ ☐ No		
☐ Does the patient have a tracheostomy tube? ☐ Yes ☐ No		
☐ Infection control concerns? ☐ MRSA ☐ VRE ☐ ESBL ☐ Other_____		
☐ Are there any other medical conditions or concerns that would make this patient unstable or unable to tolerate the procedure or receive procedural sedation? ☐ Yes ☐ No Details_____ _____		

_____ _____
Health Care Provider's Signature **Date (yyyy/ MMM/ dd)**

Any questions/concerns please contact Echo: QEH (902) 894-0067