

CARDIAC NON-INVASIVE LAB REQUISITION

 825 COXWELL AVENUE, TORONTO, ON M4C 3E7
 TEL: (416) 469-6031 / FAX: (416) 469-6458

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| <input type="radio"/> STAT | <input type="radio"/> VERBAL |
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TORONTO EAST HEALTH NETWORK

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|--|---|--|-------------|--------------------------------|--|--|--|------|---|
| INFORMATION | PATIENT'S LAST NAME: | | FIRST NAME: | | DATE OF BIRTH: | | | SEX: | |
| | | | | | DAY | MONTH | YEAR | M | F |
| | ADDRESS: | APT#: | CITY: | POSTAL CODE: | INTERPRETER? | DIABETIC? | PREGNANT? | | |
| | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | TELEPHONE NUMBER: <input type="checkbox"/> CELLULAR <input type="checkbox"/> LANDLINE | EMAIL ADDRESS FOR VIRTUAL CONSULT: | | | HEALTH CARD NUMBER: | | VERSION CODE: | | |
| HOW WOULD YOU LIKE TO BE CONTACTED REGARDING YOUR APPOINTMENT? <input type="checkbox"/> EMAIL MESSAGE <input type="checkbox"/> TEXT MESSAGE <input type="checkbox"/> PATIENT DOES NOT HAVE A CELLPHONE | | | | | | | | | |
| Child's Weight: (kg) | Child's Height: (cm) | ← Paeds <10 years old: Weight & height required | | *FOR FETAL ECHO – Weeks Gest.: | Estimated Date of Delivery: | | Multiples (Number of Fetuses): | | |
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| ADULT ECHOCARDIOGRAPH | ADULT ECHOCARDIOGRAPH | |
| | <input type="radio"/> Adult 2D Echo <input type="radio"/> Stress Echo (Bicycle) | <input type="radio"/> Contrast <input type="radio"/> Transesophageal Echocardiogram (TEE) |
| | Indication Codes for 2D Echo / Contrast / TEE: <ul style="list-style-type: none"> <input type="checkbox"/> 1. Heart murmur <input type="checkbox"/> 2. Native valvular stenosis <input type="checkbox"/> 3. Native valvular regurgitation <input type="checkbox"/> 4. Known/suspected mitral valve prolapse <input type="checkbox"/> 5. Congenital heart disease <input type="checkbox"/> 6. Prosthetic heart valve <input type="checkbox"/> 7. Infective endocarditis <input type="checkbox"/> 8. Pericardial disease <input type="checkbox"/> 9. Cardiac mass <input type="checkbox"/> 10. Pulmonary disease <input type="checkbox"/> 11. Chest pain/CAD <input type="checkbox"/> 12. Dyspnea/CHF/Edema <input type="checkbox"/> 13. Hypertension <input type="checkbox"/> 14. Thoracic aortic disease <input type="checkbox"/> 15. Neurologic/embolic events <input type="checkbox"/> 16. Arrhythmias/syncope/palpitations <input type="checkbox"/> 17. Pre-cardioversion <input type="checkbox"/> 18. Suspected structural heart disease <input type="checkbox"/> 19. ECG abnormality <input type="checkbox"/> 20. Other (specify) | Indication Codes for Stress Echo: <ul style="list-style-type: none"> <input type="checkbox"/> A. Chest pain or ischemic equivalent syndrome <input type="checkbox"/> B. ACS with non-diagnostic ECG changes with borderline significant <input type="checkbox"/> C. CHF <input type="checkbox"/> D. LV systolic dysfunction of unclear etiology <input type="checkbox"/> E. Ventricular arrhythmias <input type="checkbox"/> F. Syncope of unclear etiology <input type="checkbox"/> G. Borderline or high troponin levels in a setting other than ACS <input type="checkbox"/> H. Initial or re-evaluation of significant cerebrovascular or peripheral atherosclerosis <input type="checkbox"/> I. Equivocal or non-diagnostic results from other stress modalities <input type="checkbox"/> J. Initial or re-evaluation of patients at risk for intermediate or high global CAD risk <input type="checkbox"/> K. New or worsening chest pain or ischemic equivalent <input type="checkbox"/> L. Post MI or ACS for risk stratification <input type="checkbox"/> M. Viability in patients with known LV dysfunction post revascularization <input type="checkbox"/> N. Re-evaluation of stable patients with CAD (previous angiography, CTA/EBCT, MI, ACS or abnormal stress imaging) <input type="checkbox"/> O. Moderate or severe AS, MS, MR, aortic regurgitation or cardiomyopathy <input type="checkbox"/> P. Pulmonary hypertension <input type="checkbox"/> Q. Other (specify) |

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| FETAL / PAEDS ECHOCARDIOGRAPH | FETAL / PAEDIATRIC ECHO. | |
| | <i>(Provide weight and height if less than 10 years old)</i> | |
| | <input type="radio"/> Paediatric Echo Only <input type="radio"/> Paediatric Echo & Consultation <input type="radio"/> Fetal Echo* → _____ Weeks Gestation | |
| | Indication Codes for Paediatric Echo: <ul style="list-style-type: none"> <input type="checkbox"/> 1. Heart murmur <input type="checkbox"/> 2. Congenital heart disease <input type="checkbox"/> 3. Chest pain <input type="checkbox"/> 4. Hypertension <input type="checkbox"/> 5. Arrhythmias/syncope/palpitations <input type="checkbox"/> 6. ECG abnormality <input type="checkbox"/> 7. Post VSD repair <input type="checkbox"/> 8. Post ASD device /repair <input type="checkbox"/> 9. Post PDA device /ligation <input type="checkbox"/> 10. Post tetralogy of fallot repair <input type="checkbox"/> 11. Post TGA Switch <input type="checkbox"/> 12. Abnormal fetal echo follow-up <input type="checkbox"/> 13. Kawasaki's disease <input type="checkbox"/> 14. Other (specify) | Indication Codes for Fetal Echo: <ul style="list-style-type: none"> <input type="checkbox"/> A. Abnormal prenatal screen <input type="checkbox"/> B. Abnormal nuchal thickness _____ mm <input type="checkbox"/> C. Suspected congenital HD on anatomy scan <input type="checkbox"/> D. Chromosomal abnormalities <input type="checkbox"/> E. Maternal diabetes <input type="checkbox"/> F. Maternal meds. <input type="checkbox"/> G. Family history of congenital HD <input type="checkbox"/> H. Twins/multiples <input type="checkbox"/> I. Other (specify) |

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| STRESS | EXERCISE STRESS TEST & CONSULT |
| | <input type="radio"/> First Available Cardiologist <u>or</u> <input type="radio"/> Dr. _____ |

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| HOLTER MONITOR | HOLTER MONITOR |
| | <input type="radio"/> 72 Hour |

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| NUCLEAR MEDICINE | NUCLEAR MEDICINE |
| | <input type="radio"/> Persantine Cardiolite <input type="radio"/> Exercise Cardiolite |

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| CLINICAL | |
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| REFERRAL | Referred By: _____ M.D. |
| | Telephone: _____ |
| | Fax Number: _____ |
| | Signature: _____ |
| | Copy To: _____ |
| Billing Number: _____ | |

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|--|-------------------------|-------------------------|---|-------------------------|-------------------------|
|  | APPOINTMENT DATE: _____ | APPOINTMENT TIME: _____ |  | APPOINTMENT DATE: _____ | APPOINTMENT TIME: _____ |
| A.M. / P.M. | | | | | |

PATIENT INSTRUCTIONS

REGISTRATION:

- Please bring a list of your current medications with you.
- Also, please bring your health card and arrive 30 minutes prior to your appointment to register.
- To register, please go to the **Patient Registration Department**.
- To cancel or reschedule the appointment, please contact the Appointment Call Centre at **(416) 469-6031** (Monday - Friday, 8 a.m.- 4:00 p.m., Closed Holidays)
- For **Paediatric Appointments**, young children and babies should be fed prior to their appointment to make them less restless during their visit or test. Please bring a bottle of milk/juice and a soother. Please bring all of the child's current medications.

DIRECTIONS:

Michael Garron Hospital (formerly Toronto East General Hospital) located at 825 Coxwell Ave.

By Car

Exit at Don Mills Road South off the Don Valley Parkway and travel eastbound (turn left) onto O'Connor Drive. Turn right (travel south) at Coxwell Ave.

Metered parking is available around the hospital. Visitor parking is available off of Sammon Ave. and Mortimer Ave.

By TTC

The hospital is located just north of the Coxwell subway station. The Coxwell subway station is located between Greenwood and Woodbine along the Bloor-Danforth line.

At the Coxwell subway station, take the northbound bus (#70 or #70A) to Sammon Ave.

PREPARATION INSTRUCTIONS:

- ✓ A light meal prior to the test (e.g. dry toast & juice). Diabetic patients may include fruit & vegetables.
- ✓ No caffeine for 24 hours prior to test. This includes no coffee, tea, pop or chocolate.
- ✓ Please wear comfortable clothes & running shoes (excluding Persantine patients) as you may be asked to use a treadmill or stationary bicycle (Stress Echos only).
- ✓ Please do not use lotion or powder on your skin.
- ✓ Please bring reading glasses if needed in order to review and sign patient consent form.
- ✓ Please bring all of your current medications with them. Take all medications as usual unless otherwise directed by your doctor.
- ✓ It is best if someone the patient knows accompanies them to translate if required but translation services are available upon request.

Note: Please prepare for at least a **5 hour stay** for Nuclear Imaging Tests – Persantine and Cardiolite Exercise Tests

GENERAL INFORMATION:

Access YOUR Health Records & Appointment Information Anywhere! Anytime!

- MyChart™ is a secure website that allows you to access your health records and appointment information.
- Available 24 hours a day, 7 days per week. Anywhere in the World!
- To register for this free service, please visit the Release of Information Department.

Hand washing is important!

- Please wash your hands before, during and after you visit the hospital. Thank you.

We are a Smoke Free and Scent Sensitive building

- Many people are sensitive and/or allergic to fragrance. We ask that you please reduce the use of products that contain scents.

General inquiries: (416) 469-6580

Donations: (416) 469-6003

Business Office: (416) 469-6580 ext. 6231

Health Records:(416) 469-6580 ext. 6273

Our website: www.tehn.ca

Thank you for choosing Michael Garron Hospital



We now accept Ocean eReferrals for various clinics. The best way to find Specialist and refer your patients. For more information and to sign-up for your Ocean user account, contact Ontario eHealth at eReferral@ehealthce.ca