



# Echocardiogram Requisition



Height _____ ft/cm	Weight _____ kg/lb	Patient's Phone # _____
<b>Please confirm prior to ordering:</b> <input type="checkbox"/> Echocardiogram result will impact the treatment plan of the patient. <input type="checkbox"/> Patient is able to lie left-side down and remain still during the procedure. <input type="checkbox"/> Previous Echocardiogram? Where: _____ Date: _____ EF _____ %		
<b>Required Test:</b> <input type="checkbox"/> Transthoracic Echocardiogram (TTE) <input type="checkbox"/> Definity Contrast	<input type="checkbox"/> Transesophageal Echocardiogram (TEE) <input type="checkbox"/> Intra-Op TEE	<input type="checkbox"/> Bubble contrast <input type="checkbox"/> Stress
<b>Priority:</b> <input type="checkbox"/> Outpatient <input type="checkbox"/> Inpatient	<input type="checkbox"/> Within < 1 month <input type="checkbox"/> 4 - 7 days	<input type="checkbox"/> 3 - 6 months <input type="checkbox"/> 1 - 3 days <input type="checkbox"/> Within 24 hours (Call cardiologist on-call or Echo Dept.)
Indication for inpatient Echo: _____ ( per guidelines)		
<b>What is the relevant medical history and question you wish to be answered by the Echocardiographic examination (i.e. how will the Echocardiogram impact the treatmentplan of thepatient?)</b>  		
Patient History & Clinical Information Requisitions without appropriate indication/clinical information will be returned (Check all that apply)		
<input type="checkbox"/> <b>Murmur*</b> <input type="checkbox"/> Diastolic <input type="checkbox"/> Aortic* <input type="checkbox"/> Stenosis <input type="checkbox"/> Bicuspid <input type="checkbox"/> Mitral* <input type="checkbox"/> Stenosis <input type="checkbox"/> Regurgitation <input type="checkbox"/> Pulmonary* <input type="checkbox"/> Stenosis <input type="checkbox"/> Tricuspid <input type="checkbox"/> Stenosis	<input type="checkbox"/> Systolic <input type="checkbox"/> Regurgitation <input type="checkbox"/> Prolapse <input type="checkbox"/> Repair <input type="checkbox"/> Regurgitation <input type="checkbox"/> Regurgitation	<input type="checkbox"/> <b>Cardiomyopathy*</b> <input type="checkbox"/> Dilated <input type="checkbox"/> Hypertrophic <input type="checkbox"/> Restrictive <input type="checkbox"/> <b>Pulmonary Hypertension</b> <input type="checkbox"/> <b>Systemic Hypertension</b> <input type="checkbox"/> <b>Left Ventricular Hypertrophy</b> <input type="checkbox"/> <b>Right Ventricular Function</b> <input type="checkbox"/> <b>Left Ventricular Function</b> <input type="checkbox"/> <b>Heart Failure*</b>
		<input type="checkbox"/> <b>Diastolic Function</b> <input type="checkbox"/> <b>Myocardial Infarction</b> Date: _____ <input type="checkbox"/> Anterior <input type="checkbox"/> Inferior <input type="checkbox"/> Unknown <input type="checkbox"/> <b>Coronary Artery Bypass Graft</b> Date: _____ <input type="checkbox"/> <b>Dysrhythmia</b> <input type="checkbox"/> Atrial Fibrillation <input type="checkbox"/> Other _____ <input type="checkbox"/> <b>Source of Embolus*</b> <b>*Refer to page 2 for criteria</b>
<b>Other Indications:</b> <input type="checkbox"/> Trauma <input type="checkbox"/> Chemotherapy <input type="checkbox"/> CAD <input type="checkbox"/> Pericardial disease <input type="checkbox"/> Pregnant <input type="checkbox"/> Aortic aneurysm <input type="checkbox"/> Infective Endocarditis* <input type="checkbox"/> Transplant: type? _____ <input type="checkbox"/> Pericardial effusion		
<b>Symptoms:</b> <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Palpitations <input type="checkbox"/> Lightheadedness/Syncope* <input type="checkbox"/> Chest pain <input type="checkbox"/> Fatigue <input type="checkbox"/> Other _____ <b>*Refer to page 2 for criteria</b>		
<b>Prosthesis (check one):</b> <input type="checkbox"/> Aortic <input type="checkbox"/> Mitral <input type="checkbox"/> Tricuspid <b>Type/Manufacturer</b> _____ <b>Size</b> _____ <b>Date Implanted</b> _____		
Attending Physician _____ MSC# _____		Signature _____ Phone # _____
<b>Office use only      FAX REFERRAL TO APPROPRIATE SITE: SEE PAGE 3</b>		
Scheduled Appointment Date _____ Time _____ <input type="checkbox"/> Preliminary Report with Patient		

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## \*Guidelines for Ordering Transthoracic Echocardiograms (TTE)

### Heart Failure

#### Appropriate TTE:

- **Initial evaluation** of HF based on signs, symptoms or abnormal test **results**
- Known HF with decompensation **without** a clear precipitant
- To guide therapy i.e. candidacy for ICD, etc.

#### Inappropriate TTE:

- Known HF with decompensation due to a **clear precipitant** (i.e. dietary or medication noncompliance)
- Routine surveillance of LV function in a patient who had a TTE within the past year

### Endocarditis

#### 1. *Diagnosis of endocarditis (either native or prosthetic valve)*

##### Appropriate TTE:

- Fever and a **positive blood culture or new murmur**

##### Inappropriate TTE:

- Transient fever with no bacteremia or new murmur
- Transient bacteremia from a documented non-endovascular source or infection (i.e. urinary tract infection, skin abscess)

#### 2. *Follow-up of known endocarditis*

##### Appropriate TTE:

- Patient at high risk of developing a complication (i.e. abscess) or clinical status changes (i.e. heart failure, heart block).

##### Inappropriate TTE:

- Routine surveillance of a vegetation when patient management will not change

### Lightheadedness/Syncope

#### \**Rule out cardiac cause of lightheadedness or syncope*

##### Appropriate TTE:

- Patient with **actual syncope** or with clinical symptoms and signs suggestive of a cardiac cause of lightheadedness (i.e. murmur or aortic stenosis or hypertrophic cardiomyopathy, or signs/symptoms of heart failure)

##### Inappropriate TTE:

- Patient did not have actual syncope (i.e. loss of consciousness) and has no other symptoms or signs of cardiac disease

### Murmur/Valve Disease

#### *Cardiac murmur or known valvular disease*

##### Appropriate TTE:

- **Reasonable** suspicion of valvular disease on exam (i.e. diastolic murmur, murmur 3/6, other findings on exam)
- Known valvular disease with a change in clinical status (i.e. HF, syncope) or cardiac exam
- No change in cardiac exam or clinical status with known mild stenosis/regurgitation with a TTE within 3 years or moderate/severe stenosis/regurgitation with a TTE within past year

##### Inappropriate TTE:

- No change in cardiac exam or clinical status, prior TTE did not reveal valvular disease
- Known trace regurgitation, mild stenosis/regurgitation with TTE within 3 years or moderate/severe stenosis/regurgitation with a TTE within past year
- No other symptoms or signs of valvular disease on exam (i.e. flow murmur)

### Transient Ischemic Attack (TIA)/Stroke

##### Appropriate TTE:

- **Unexplained** TIA/stroke without evidence of cerebrovascular disease and in whom a clinical therapeutic decision (i.e. **anticoagulation or cardiac intervention**) will depend on the results of echocardiography
- TIA/stroke **concurrent** with a cardiac ischemic event or systemic embolic event
- **Suspected** infective endocarditis or cardiac mass

##### Inappropriate TTE:

- A **known cause** of cardiac source already exists and TTE **would not change management**. This may include known **cardiac arrhythmia** (atrial fibrillation), **low left ventricular ejection fraction**, **significant congestive heart failure**, or **known cardiac thrombus or valvular source** of emboli)

*Guidelines for the Provision of Echocardiography in Canada (2004) Recommendations of a Joint Canadian Cardiovascular Society and Canadian Society of Echocardiography Consensus Panel.*

*American Society of Echocardiography Recommendations for Quality Echocardiography Laboratory Operations (2011). doi:10.1016/j.echo.2010.11.006*

*Transthoracic Echocardiography Utilization in Ontario: Appropriateness and Specific versus General Indications (2017). doi: https://doi.org/10.1016/j.cjca.2017.07.345*

*Improving the Appropriate Use of Transthoracic Echocardiography: The Echo WISELY Trial. (2017). doi: 10.1016/j.jacc.2017.06.065.*

*Intersocietal Accreditation Commission (IAC) Echocardiography Standards and Guidelines for Adult Echocardiography Accreditation (2018)*

*Guidelines for the Use of Echocardiography in the Evaluation of a Cardiac Source of Embolism. (2016). doi: 10.1016/j.echo.2015.09.011*

# Echocardiogram Requisition



## BENCHMARK WAIT TIMES FOR ACCESSING ECHOCARDIOGRAPHY

Urgency Category	Recommended wait time	Defined by: Examples
Emergent	Within 24 hours	Hemodynamically unstable patients with suspected certain cardiovascular conditions (e.g. pericardial effusion with tamponade, mechanical complications, post myocardial infarction)
Urgent/Semi urgent	Within 7 days	Critically ill patients who do not meet the definition of emergent and patients with a condition that could deteriorate rapidly (e.g. symptomatic aortic stenosis)
Scheduled/Non urgent	Within 30 days	All patients who do not fall into the previous categories (e.g. assessment of murmurs in asymptomatic individuals, assessment of left ventricle mass)

*Adapted from: 2008, CCS Wait time benchmarks: Treating the Right Patient at the Right Time: Access to Echocardiography in Canada*

### \* INCOMPLETE REQUISITION FORMS WILL BE RETURNED \*

Site	Address	Phone	Fax
<b>Abbotsford Regional Hospital</b>	Medical Imaging 32900 Marshall Road, Abbotsford, BC V2S 0C2	604-851-4868	<b>604-870-7518</b>
<b>BurnabyHospital</b>	Medical Imaging 3935 Kincaid Street, Burnaby, BC V5G 2X6	604-412-6271	<b>604-412-6181</b>
<b>Eagle Ridge Hospital</b>	Medical Imaging 475 Guildford Way, Port Moody, BC V3H 3W9	604-469-3172	<b>604-469-3209</b>
<b>Jim Pattison Outpatient Care and Surgery Centre</b>	Medical Imaging 9750 - 140 Street, Surrey, BC V3T 0G9	604-582-4550 Loc.763939	<b>604-582-3766</b>
<b>Langley Memorial Hospital</b>	Medical Imaging 22051 Fraser Highway, Langley, BC V3A 4H4	604-533-6405	<b>604-533-6456</b>
<b>Peace Arch Hospital</b>	Medical Imaging 15521 Russell Avenue, White Rock, BC V4B 2R4	604-535-4510	<b>604-535-4559</b>
<b>Ridge Meadows Hospital</b>	Medical Imaging 11666 Laity Street, Maple Ridge, BC V2X 5A3	604-463-1849	<b>604-466- 7939</b>
<b>Royal Columbian Hospital</b>	Nuclear Medicine/Medical Imaging 330 E. Columbia Street., New Westminster, BC V3L 3W7	604-520-4244	<b>604-520-4803</b>
<b>Surrey Memorial Hospital</b>	Medical Imaging 13750 96th Avenue, Surrey, BC V3V 1Z2	604-582-4550 Loc.763939	<b>604-582-3766</b>

### IMPORTANT PATIENT INFORMATION

- Plan to arrive 15 minutes early to give yourself adequate time for parking.
- An interpreter must accompany patients who do not speak fluent English or exam may be cancelled.
- Children and other third parties are not permitted in the examination rooms. Please ensure that children under the age of 12 have someone to look after them during your exam or we will not be able to do your exam.

**\*\*Please bring your Care Card, WorkSafe BC or ICBC information and Photo Identification\*\***