JOSEPH BRANT HOSPITAL

CARDIOLOGY REQUISITION

1230 North Shore Blvd. Burlington, ON
Phone: (905)336-4101 Fax:(905) 681-4818

LOCATION	JBH UNIQUE ID:	
☐ Inpatient	Patient Name:	
☐ Emergency	Address:	
☐ Outpatient	Date of Birth:	Phone:
	Health Card No:	Version Code:

RELEVANT CLINICAL INFORMATION

RELEVANT PATIENT HISTORY

Patient Height:	Patient weight:			
☐ Y ☐ N Pre-Op assessment?	Date of surgery?			
☐ Y ☐ N Artificial Valve Surgery?	☐ Aortic	☐ Mitral	☐ Tricuspid	☐ Pulmonary
Type/Manufacturer:	Size:	Date implanted:		
☐ Y ☐ N Any other known allergies?	If so, indicate:			
☐ Y ☐ N Taking any anticoagulants?	If so, indicate:			
☐ Y ☐ N Can patient consent?	If not, a family member or translator must be present at time of exam			

RELEVANT PREVIOUS IMAGING(Required)

☐ Y ☐ N Has the patient had any relevant previous imaging outside of JBH?

Dates/Locations:

All relevant outside Imaging Reports must be faxed to JBH to expedite Booking

ECHOCARDIOGRAPHY	NUCLEAR CARDIOLOGY
☐ 2D ECHO WITH DOPPLER	☐ EXERCISE MYOCARDIAL PERFUSION (CARDIOLITE)
☐ ECHO (with CONTRAST)	☐ PERSANTINE MYOCARDIAL PERFUSION (CARDIOLITE)*
☐ ECHO - SALINE BUBBLE STUDY	☐ MUGA/RADIONUCLIDE ANGIOGRAM
	☐ THALLIUM VIABILITY
☐ STRESS ECHO - EXERCISE	
☐ STRESS ECHO - EXERCISE (with CONTRAST)	**RECOMMENDED IF: Unable to Exercise or LBBB or Paced*
☐ STRESS ECHO - DOBUTAMINE	* *CONTRAINDICATED IF: Significant Bronchospasm*
☐ STRESS ECHO - DOBUTAMINE (with CONTRAST)	
☐ TRANSESOPHAGEAL ECHO (TEE) **(Cardiologist consult required)**	

CARDIAC STRESS TEST	HOLTER MONITORING
☐ EXERCISE TEST (GXT)	☐ 24 HOUR
☐ LOW LEVEL EXERCISE TEST (MODIFIED)	☐ 48 HOUR
	☐ 7 DAY

Physician(Print)		**Signature:**	
Phone:	**Fax:**	**Date:**	**Copies To:**

ALL INCOMPLETE OR UNSIGNED REQUISITIONS WILL BE RETURNED

JBH USE ONLY ☐ R ☐ L	Time: _____	Signature: _____	
IV ACCESS	Size:	Designation:	

APPOINTMENT DETAILS (JBH Use Only)

Date:	Time:	Is Preparation Required?	☐ Yes ☐ No