NHH
Northumberland Hills Hospital

Patient label

NHH OUTPATIENT TRANSTHORACIC ECHOCARDIOGRAM REFERRAL
FAX TO 905-373-6922

Patient Name	DOB
Patients Daytime Phone Number	OHIP Number
Patients email	
Referring Provider Referring Provider CPSO #	Office Fax

URGENCY: ☐**Routine** ☐**Urgent** ☐**Stat**

Reason for Test		**TEST**
☐**Arrythmia**	☐**LV Function**	☐ **Transthoracic Echocardiogram**
☐**Chest Pain**	☐**Murmur**	
☐**ACS/MI**	☐**Palpitations**	
☐**Dizziness/Syncope**	☐**Shortness of Breath**	
☐**Stroke Workup**	☐**Pre-Transplant Work-up**	
☐**Pre-Chemotherapy**	☐**Cardiac Device Interrogation**	
☐**Post Follow-up Chemotherapy**	☐**Endocarditis**	
☐**None of These**		

Additional Comments: