BC Children's Hospital

Encounter #______________

CHILDREN'S HEART CENTRE
Clinical Services Request
*please see reverse for instructions

PRINT Demographic Data OR Place Patient Demographic Label
BCCH MRN:
Patient Name (LAST, FIRST):
DOB:
Patient Phone #:
PHN:

REFERRING SERVICE MUST COMPLETE THIS SECTION – Incomplete Form WILL Delay Service!
(Please Print Clearly)

DATE OF REQUEST:

REFERRING PHYSICIAN / NP (Please Print and sign)

BILLING NUMBER | CONTACT NUMBER

***Inpatient ECHO requests (except Oncology) require approval from the cardiology service**

❑OUTPATIENT (Consult required) ❑INPATIENT
Room________ Unit ________

Inpatient Echo Approver

ISOLATION (❑CONTACT ❑DROPLET ❑PROTECTIVE)

SERVICES REQUESTED
(See Reverse for Instructions)

❑ECHO*
❑ECG
❑HOLTER MONITOR
❑STRESS TEST
❑CARDIOLOGY CONSULT

Patient Height (cm)

Patient Weight (kg)

PERTINENT PATIENT HISTORY (Please provide reason for referral and cardiac diagnosis if known)

CARDIOLOGY MD / NP USE ONLY

CONSULTING CARDIOLOGIST | BOOKING TIMEFRAME

CONSULT ❑New Patient ❑Follow-Up ❑CPAC ❑Nurse Transition ❑Exercise Prescription ❑Dietitian

ECHO	**ECG**	**Pacemaker**	**STRESS TESTING**
❑ Booked sedation ❑ May need sedation ❑ TEE ❑ Bubble Study ❑ MIBI ❑ Research ❑ Transit Time	❑ Resting 12 Lead ❑ High 12 Lead ❑ Signal Average ECG ❑ Cardiac Screen/ Event Monitor **HOLTER** ❑ Hook-Up, 24 Hour ❑ Hook-Up, 48 Hour ❑ Scan	❑ ICD ❑ CRT ❑ Pacemaker check, Single ❑ Pacemaker check, Dual ❑ Loop Recorder ❑ 24hr Ambulatory Blood Pressure Monitor	❑ with Oximetry ❑ VO2 ❑ Treadmill (❑ BCCH or ❑ Bruce) ❑Upright Cycle (Protocol: __________) ❑ **Stress ECHO** ❑ Dobutamine Echo

APPOINTMENT DATE/TIMES

APPOINTMENT NOTES

Interpreter needed? ❑No ❑Yes - Language:
❑ Consult before ECHO ❑Consult before STRESS

KEY INFORMATION REQUIRED

MD/NP SIGNATURE

(White)EchoLab (Yellow)ECG

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