PROTA CLINIC

#4 – 930 Lorimer Boulevard
Winnipeg, MB R3P 1G1
Phone: 204-837-7682
Fax: 204-488-6430

Please PRINT CLEARLY (Or affix demographic label)

Date _____ **Patient Name** _____
Birth Date _____ **Gender** ◻ **Male** ◻ **Female**
MHSC # _____ **PHIN #** _____
Address _____
City _____ **Province** _____ **Postal Code** _____ **Cell Phone** _____
Home / Work Phone _____ **Emergency Contact & Phone** _____

PATIENT INFORMATION (Please print and/or circle or check)

Height (cm) _____ **Weight (kg)** _____ **LNMP** _____
Patient Pregnant ◻ **Yes** ◻ **No** **If Yes, Due Date** _____
Patient Nursing: ◻ **Yes** ◻ **No** **Patient Allergies** _____

STUDY REQUESTED

◻ **ECHOCARDIOGRAM** ◻ **ULTRASOUND and area to be scanned** _____
◻ **Urgent** ◻ **Semi-Urgent** ◻ **Elective**
Previous relevant exams, dates and locations _____
_____

HISTORY AND PROVISIONAL DIAGNOSIS. (Specify if patient on infection control precautions)

ECHOCARDIOGRAM CLINICAL HISTORY / STUDY QUESTION – Mark all that apply and add specific details if available.

Cognitive Heart Failure (CHF) ◻ Radiographic Confirmation ◻ Elevated BNP ◻ Clinical ◻ Other(specify)_____	**Endocarditis** ◻ +ve blood cultures (Bug_____) ◻ Intermediate to high clinical likelihood(eg. Duke Score) ◻ Other(specify)_____	**Pulmonary Artery (PA) Pressure** ◻ Known pulmonary hypertension ◻ Other(specify)_____ _____ _____
Left Ventricular (LV) Function ◻ Shortness of Breath (SOB) ◻ Large MI by ECG or CK_____ ◻ Rule out apical thrombus with recent anterior MI ◻ Other(specify) _____	**Pericardial Effusion** ◻ Strongly suspected ◻ Follow-up of known effusion ◻ Other(specify)_____	**Ascending Aorta or Aortic Root** ◻ STRONGLY suspected ◻ Follow-up of documented ascending aorta or root aneurysm (Prior size_____) ◻ Other(specify)_____
Valve Disease (Including Prosthesis) ◻ Prosthetic valve (List size/type & date inserted)_____ ◻ Known valve disease_____ ◻ Other(specify)_____	**Source of Embolism** ◻ Confirmed associated heart disease ◻ Known atrial fibrillation ◻ Other(specify)_____	**Congenital Heart Disease** ◻ Must provide details_____ _____
Rule Out Structural Heart Disease ◻ Signs/symptoms of heart disease ◻ Documented significant arrhythmia ◻ Other(specify)_____	**Murmur** ◻ Associated cardiac symptoms ◻ Other eg. murmur NYD ◻ Type (systolic/diastolic) & grade_____ ◻ Other(specify)_____	**Other Indications (details)** _____ _____ _____ _____ _____

AUTHORIZED PHYSICIAN INFORMATION – Print Clearly

Signature (Print and Sign) _____
Address _____
Phone _____ **Fax** _____
Additional Reports to: _____ **Fax** _____

Appointment Date/Time: _____ **(Office Use Only)**