LAC+USC HEATHCARE NETWORK
DIVISION OF CARDIOVASCULAR MEDICINE

Transthoracic ECHOCARDIOGRAM Referral Worksheet

Attn:>>>>Completed forms will expedite processing. Thank-You*

Request Date: _____

PATIENT Name: _____ DOB: _____

MRUN: _____ Height _____ ' _____ " Weight: _____ lbs

PATIENT ADDRESS _____

PATIENT CONTACT PHONE # __(_____)_____

Clinic Name/Location : _____

Ordering Physician Name: _____ Pager _____
(Required)

Referral Coordinator: _____ Phone#/Pager _____

INDICATIONS/REASON FOR EXAM:

- ☐ Left Ventricular Function
- ☐ Regional Wall Motion Abnormality
- ☐ Evaluation of Murmur
- ☐ Pericardial Effusion
- ☐ Pericardial Effusion-Constrictive
- ☐ Tamponade Physiology
- ☐ Valve Dysfunction
- ☐ LA Thrombus LV Thrombus
- ☐ Aortic Dissection
- ☐ Endocarditis/Vegetations
- ☐ Interatrial shunt
- ☐ Intraventricular Shunt
- ☐ Right Ventricular Function
- ☐ Pulmonary Hypertension

☐ Prosthetic Valve: Model & Size _____ Year Implanted _____
REQUIRED

☐ Other Indication _____
Limited free text available

ISOLATION TYPE: AIRBORN CONTACT DROPLET NONE PROTECTIVE
>>>>>REASON FOR ISOLATION:

HISTORY:

☐ Tobacco	☐ Hypertension	☐ Hyperlipidemia	☐ Diabetes
☐ CABG	☐ MI	☐ CAD	☐ Chest Pain
☐ Murmur	☐ Valve Disease	☐ Positive Blood Culture	☐ Prosthetic Valve (see above)
☐ Dyspnea	☐ CHF	☐ A-Fib/flutter	☐ Cardiomyopathy
☐ None			

Do Not make boxes-above items are cardiac related

>>>*INCOMPLETE REQUESTS CANNOT BE PROCESSED-COMPLETE ALL FIELDS<<<

Ordering Physician's Signature _____ Date _____

(Rev. 4/30/06 LH)