UNIVERSITY OF OTTAWA
HEART INSTITUTE
INSTITUT DE CARDIOLOGIE
DE L'UNIVERSITÉ D'OTTAWA

Cardiac Diagnostic Imaging Requisition

Booking / Information / Cancellations
Phone: 613-696-7066 Fax: 613-696-7098
40 Ruskin Street, Ottawa ON K1Y 4W7
www.ottawaheart.ca

TEST DATE: **TIME:** Medical record number

PRIORITY: ❑ **Inpatient** – Ward: ❑ **Outpatient** – Urgency: ❑ less than 2 weeks ❑ less than 1 month ❑ Elective
For CT and MRI: ❑ *Urgent* ❑ *Next working day*

Surname	First name	Maiden name	
Date of birth /YY /MM /DD — Gender: M ❑ F ❑	Provincial Insurance number	Version code	Expiry date
Address	City	Province	Postal Code
Telephone number: (Home): (Alternative):		Research ❑ No ❑ Yes – Specify study name:	

EXAMINATION(S) REQUESTED

CARDIAC STRUCTURE AND/OR FUNCTION ASSESSMENT

❑ Echocardiography (Colour / Doppler)
- ❑ With Bubble Study

❑ Transesophageal Echocardiography (TEE)
❑ Ventricular Function and Volume Scan (MUGA)
Cardiac MRI (Anatomy & Function):
→ ***Complete Diagnostic Imaging Requisition for MRI***

STRESS TESTING / ISCHEMIC TESTING

❑ Cardiopulmonary Stress Test
❑ Exercise Treadmill Stress Test
Exercise Protocol: _____

StressNuclear / PET Myocardial Perfusion & Function:
- ❑ Exercise SPECT
- ❑ Persantine SPECT
- ❑ Persantine PET
- ❑ Dobutamine PET

} ❑ Either SPECT **OR** PET (first available)

Stress Echocardiography:
- ❑ Exercise Stress Echo
- ❑ Dobutamine Stress Echo

CARDIAC CT / NON-INVASIVE ANGIOGRAPHY

❑ CT Coronary Angiography
❑ Coronary Calcium Score
❑ Pulmonary Vein and Left Atrium Study
❑ Other:

MONITORING

❑ Ambulatory ECG Monitoring (Holter)
❑ Ambulatory ECG Monitoring (14 day-outpatient only)
❑ 24-hour Ambulatory Blood Pressure Monitor

VIABILITY / TISSUE CHARACTERIZATION

Cardiac PET (Viability, Sarcoidosis, Other):
→ ***Complete separate FDG PET Requisition***
Cardiac MRI (Viability, Cardiomyopathy, Other):
→ ***Complete Diagnostic Imaging Requisition for MRI***

OTHER

❑ Carotid Doppler
❑ Femoral Doppler (for access complication)

CLINICAL INFORMATION

REASON FOR REQUEST: * mandatory for Nuclear and PET

Cardiology Consult Request? ❑ Yes ❑ No

* Height: _____ cm
* Weight: _____ kg

- ❑ Chest Pain
- ❑ Dyspnea
- ❑ Palpitations
- ❑ Arrhythmia
- ❑ Syncope
- ❑ Post PCI / CABG
- ❑ History of MI
- ❑ Stroke / TIA
- ❑ Heart Function / Failure
- ❑ Murmur / Valve Disease

Pacemaker patient? ❑ Yes ❑ No
Defibrillator patient? ❑ Yes ❑ No
Appointment booked:
_____
Sleep Apnea? ❑ Yes ❑ No
- If yes, uses CPAP? ❑ Yes ❑ No
Diabetic? ❑ Yes ❑ No
Metformin? ❑ Yes ❑ No

For CT: Serum Creatinine: _____ Date: _____
At risk of heart failure? ❑ No ❑ Yes – If yes, hold Lasix? ❑ Yes ❑ No

ALLERGIES:

MEDICATIONS: Please list medications.

Resident's name (print)

Physician's name (print)

Physician's signature

Telephone no. | Fax no.

Physician's billing no.

Copy of report to: Family physician; Other physician(s)

FOR OFFICE USE ONLY

Protocol/procedure code