DARTMOUTH-HITCHCOCK MEDICAL CENTER

One Medical Center Drive
Lebanon, NH 03756
(603)650-5000

Cardiac Ultrasound Laboratory

(603)650-6152

Fax# 603-650-6327

ECHO SPECIAL TESTS REQUEST FORM

Request Date: ____________________ Test Date & Time: ______________________

Patient Name: _____________________________________ DOB: __________________

Patient MRN: __________________________ Outpt or Inpt Room #:________________

Requesting Physician: ______________________________ Phone: ________________

Person Requesting: _________________________________ Phone: ________________

STRESS ECHO PROCEDURE REQUEST

Procedure:	**DOBUTAMINE** (NON-EXERCISE)		**EXERCISE ECHO** (STRESS EXERCISE)
History (required):	ICD:	NO	YES
	Pacemaker:	NO	YES
	Beta Blocker:	NO	YES

If YES: Hold for **24 hours** _______ **48 hours** _______ **ON MEDS**________

Indication:

___ Ischemia
___ Viability
___ Chest Pain
___ Adequacy of Medical Therapy
___ Pre-OP: Type of Surgery ___________________
___ Valve Disease: Type ________________________
___ Hemodynamic Study (change in MR/PASP)
___ Other: ___________________________________

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TRANSESOPHAGEAL REQUEST

History:			
	Difficulty Swallowing:	NO	YES
	Esophageal Problems:	NO	YES
	Patient able to give consent:	NO	YES

Indication:

CVA/Stroke:_______________________
Endocarditis: _____________________
Valve Disease:_____________________
LA Thrombus: _____________________
Atrial Arrhythmia:__________________

OR BOOK: ______________________
RES FORM: _____________________
Echo Lab MD: _____________________
CIS: ____________________________
Confirmed w/ pt:___________________
Package Sent: _____________________

Pt Location/Room#: _____________

Rev: 7/10/07 cc