

Cardiology Plus (Calgary) Inc.



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Patient Label

Echocardiogram Requisition

Does patient have a nuclear medicine scan scheduled? Yes No

If yes, Date: _____

There must be at least 10 days between a nuclear scan and an echocardiogram.

Previous ECHO? Yes (PLEASE attach report)
 No

Family Physician (Name)

Office Location:

APPOINTMENT

Date: _____

Time: _____

Send additional reports to:

Physician Name

Physician Name

History and Provisional Diagnosis

Reason for test:

Referring Physician Signature

Office Location

Referring Physician Name (*Please Print*)

Office Telephone Number

PLEASE FAX COMPLETED REQUISITION TO 403-571-8658