Kingston Health Sciences Centre
Centre des sciences de la santé de Kingston

Hôpital Hotel Dieu Hospital

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Fax: 613-548-1387

Ext 3980

Name:
Date of Birth:
CR Number:
Telephone number:

# Trans-esophageal Echocardiogram Order Form

**Date: _____**

***Indication: Choose one:***

☐ **Endocarditis** ☐ **Cardiac Source of embolus** ☐ **Native valve disease**

☐ **Prosthetic valve disease** ☐ **Shunt** ☐ **Pre-ablation**

☐ **Other (please specify) : _____**

**Relevant clinical history (include type and size of prosthetic valve if applicable):**

_____

**Is there a previous transthoracic study and/or TEE? If so, please attach previous reports.**

**Required Information: Does the patient have:**

History of esophageal surgery/injury/stricture: Yes ☐ No ☐
History of difficulty swallowing: Yes ☐ No ☐
History of cirrhosis/esophageal or gastric varices: Yes ☐ No ☐
Recent upper GI bleed: Yes ☐ No ☐
Previous upper endoscopy: Yes ☐ No ☐
If yes, were there any abnormalities in the esophagus: _____
Are there any respiratory concerns for sedation: Yes ☐ No ☐
If yes, please specify: _____
History of IV drug use: Yes ☐ No ☐
Is the patient on anticoagulants? Yes ☐ No ☐
If warfarin, most recent INR: _____ Date of test: _____
Can the patient provide informed consent: Yes ☐ No ☐
If no, a substitute decision maker must come with the patient to the appointment.

**If this test is urgent, the ordering physician must speak directly to the Echocardiographer (613-549-6666 ext 3980).**

**Ordering Physician Name: _____ Signature: _____**

**Attending Name (please print): _____ Contact number: _____**

**INCOMPLETE REQUISITIONS WILL BE RETURNED.**

**FOR ECHO LAB USE ONLY:**

**Approved by: _____ Date: _____**