FETAL ECHOCARDIOGRAM REQUEST
PLEASE FAX ALL REQUESTS TO 519-685-8584

Name _____

D.O.B. _____

Address _____

Phone # _____

O.H.I.P _____

E.D.C. ____/____/____ **Gestational Age** _____
YY MM DD

Please Attach Ultrasound Report

Referring Physician(s): _____

***Referring Physician(s) FAX NUMBER:** _____

Reason for Study (PLEASE BE SPECIFIC):

Arrhythmia _____

Previous Infant CHD _____

CHD in Mother (Please attach Mothers Echocardiogram report) _____

_____

Suspected CHD _____

Non-Cardiac Anomaly _____

Other _____

For Office Use Only
Date Received: _____
Appt Date: _____
Booked By: _____

Please notify the patient
****Note: No Prep (Full Bladder NOT necessary)**
We require a copy of the patients Ultrasound report