Hartford Hospital
A Hartford HealthCare Partner

6804

Request for Outpatient Echocardiography Evaluation

(860) 545-2976
Fax: (860) 545-5631 ***or to schedule an appt:***
Central Scheduling
(860) 696-3000
Fax: (860) 696-3025

Name: _____ , _____
Last *First*
Address:_____
City_____ State _____ Zip_____
Home Phone:_____
Work Phone: _____
DOB: _____ / _____ / _____

Date Exam Requested _____ / _____ /_____ **Height _____'_____" Weight_____ lbs**

Transthoracic (TTE) Echocardiography

☐ Comprehensive Echocardiogram
☐ Comprehensive Echocardiogram w/Contrast
☐ Comprehensive Echocardiogram w/Saline Contrast
☐ Comprehensive Echocardiogram w/ AV Optimization
☐ Limited Echocardiogram

Transesophageal (TEE) Echocardiography

☐ Transesophageal Echocardiogram
☐ Transesophageal Echocardiogram w/Cardioversion

Stress Echocardiography

☐ Exercise Echocardiogram
☐ Dobutamine Echocardiogram

Please complete for TEE w/Cardioversion:

☐ Echo lab M.D. to perform cardioversion
☐ Ordering M.D. to perform cardioversion
☐ Admission for anti-arrhythmic initiation

Reason For Request/Clinical Indications: _____

Ordering Clinician:
Signature: _____
Date: ____ /____ / ____ Time: _____
Requesting Physician:
Signature: _____
Date: ____ /____ / ____ Time: _____
Print Name:_____
Beeper / Phone: _____
CC: _____
CC: _____
Insurance Pre-Authorization: