

CardioRespiratory Department

TRANSESOPHAGEAL ECHO (TEE) REQUISITION

Patient Name: _____

Date of Birth: _____

Oakville-Trafalgar Memorial Hospital 1st Floor Phone: (905) 338-4686 Fax: (905) 815-5082

- ◆ All requests for TEE must include:
Relevant history and physical OR consult note from Cardiology/Neurology/Infectious Disease
- ◆ 2D echo may be performed if no recent (< 6 months) echo images available for review and TEE is at discretion of OTMH cardiologist upon review of 2D echo
- ◆ TEE requests without echo imaging at Oakville/Milton/Georgetown sites MUST include relevant imaging reports

Please instruct your patient:

1. Nothing to eat or drink from midnight the night before the test. Patient may take MORNING medications with sip of water
2. Patient will receive sedation; therefore, must arrange transport home by an adult after the test

Provide Indication: (** Standards for Provision of Echocardiography in Ontario – 2015 **)

- Non-diagnostic transthoracic study, either due to technical limitations or failure to fully characterize a potentially significant finding
- Assessment of structure and function of cardiac valves to assess feasibility of surgery or catheter-based intervention
- Patient selection, guidance and monitoring of interventional procedures including, but not limited to, device closure of intra-cardiac shunt and radio-frequency ablation
- Detection of cardiac source of embolus in the absence of established causative pathology
- Evaluation of patients with suspected aortic dissection or aortic disease not fully evaluated by other imaging modalities
- Detection of atrial thrombus in patients prior to cardioversion or interventional procedures
- Moderate or high risk for endocarditis when TTE is negative or inconclusive
- Detection of valvular and peri-valvular complications in high risk endocarditis patients such as patients with staphylococcal bacteremia
- Other: _____

Which criteria apply to your patient:

- Complex congenital heart disease
- Critical aortic stenosis or mitral stenosis
- History of esophageal tear/varices/upper GI bleed/esophageal surgery/esophageal stricture
(attach recent UGI endoscopy report)
- Diabetes – please check: Type 1 Type 2. Instruct patient on diabetes medications while NPO

Referring Physician – Print Name: _____ Physician Signature: _____

Date: (dd/mm/yyyy) _____ Physician Phone: _____