

TRANSTHORACIC ECHOCARDIOGRAM

DEAR _____

This is a letter to remind you of your scheduled appointment for:

(test/date/day)

Please check in at:

<input type="checkbox"/> MN Heart Clinic Suite W300 952-836-3770	<input type="checkbox"/> Fairview Southdale Hospital Crosstown Lobby 952-924-1450	<input type="checkbox"/> Fairview Ridges Hospital Cardiopulmonary Dept 952-892-2140
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Please complete the attached medication form and bring with you to your next appointment.

Please register in _____ at _____
(department/location) (time)

INSTRUCTIONS FOR EXAM:

1. Plan 1-1 ½ hours for the exam.
2. Wear a comfortable 2 piece outfit.
3. Please check in 15 minutes prior to your appointment time.

Please be advised that if you are having your procedure performed at the hospital there is the chance that an emergency may arise and your doctor may not be able to start your procedure at its originally scheduled time.

This imaging test is billed as an outpatient hospital procedure. For Fairview pricing, please call 612-672-1048 or contact your insurance company for further information. You will be responsible for charges not covered by your insurance.

If you have no insurance and are self-paying, please call 952-924-8440.