

NAME -----

DATE \_\_\_\_\_

ADDRESS -----

PHONE # -----

**Your child was screened by echocardiography for the following:**

HYPERTROPHIC CARDIOMYOPATHY      -----absent      ----- present

AORTIC STENOSIS      -----absent      ----- present

DILATED CARDIOMYOPATHY      ----- absent      \_\_\_\_\_ present

**If any of the above are present you must contact your primary care doctor or cardiologist office.**

\_\_\_\_\_ MD