



NAME _____

Please complete or give us a copy of the patient's demographic sheet.

Address: _____ Zip: _____

Home Phone: _____ Work: _____ Cell: _____

Date of Birth: _____ SS # _____

Insurance: _____ Policy # _____

Diagnosis or 1CD-9 code _____

Ordering Physician _____ Dr. Signature _____

ORDERING PHYSICIAN Telephone _____ FAX _____

New Patient Consultation

CARDIAC STRESS TESTING

Nuclear Stress Test/Myocardial Perfusion Test

MUGA Scan (Ejection Fraction Determination)

Dobutamine Stress Echocardiogram

Stress Echocardiogram

Treadmill (EKG) Stress Test

Patient can walk

Patient unable to walk

Height _____

Weight _____

CARDIAC ULTRASOUND

Complete Echocardiogram

VASCULAR DOPPLERS

Duplex Doppler Scan Carotid Arteries, Complete Bilateral

Duplex Doppler Scan Renal Arteries

Duplex Doppler Scan Abdominal Aorta

Duplex Doppler Scan Mesenteric Arteries

Lower Extremity Arterial (No imaging w/blood pressures) with exercise w/o exercise

AB1 Only

Upper Extremity Arterial (No imaging w/blood pressures)

Groin Duplex Right Groin Left Groin Bilateral

Duplex Doppler Scan Venous Lower Extremity Right Leg Left Leg Bilateral

Duplex Doppler Scan Venous Upper Extremity Right Arm Left Arm Bilateral

OTHER

Resting (EKG) -12 lead

Holter Monitor 24 hour 48 hour

Event Recorder - 30 days

PLEASE FAX: Referral or Pre-Auth (if needed)

Appropriate medical records for new patient appointments

Additional Comments: _____