



PO7070



ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

**NONINVASIVE CARDIAC SERVICES
ECHO, EKG, HEART MONITOR AND
STRESS TESTING ORDER**

Date: _____

Patient Name: _____ Date of Birth: _____ Gender: _____

Patient Phone: _____ **Patient must call to schedule**

PLEASE ATTACH DEMOGRAPHICS, MEDICATION AND ALLERGIES LIST

Insurance Authorization Number: _____ Must be included for scheduling
This Is the Responsibility of the Ordering Provider's Office

Provider: (PRINT) _____ Phone: _____

Fax: _____

Authorizing Provider's Signature: _____

Scheduling preference: Urgent (1-3 days) 1-2 weeks w/in 1 month w/in 3 months
 other _____

EXAM	ORDER QUESTIONS
<p>TRANSTHORACIC ECHOCARDIOGRAM</p> <p><input type="checkbox"/> Standard TTE</p> <p><input type="checkbox"/> Limited or Follow up TTE Consider for the following indications:</p> <p><input type="checkbox"/> LV/RV function with IVC assessment only</p> <p><input type="checkbox"/> Pericardial effusion assessment only</p> <p><input type="checkbox"/> Pulmonary embolism and RV function only</p>	<p>Associated Diagnosis _____ ICD10 _____</p> <p>Indication: <input type="checkbox"/> Chest Pain <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Palpitations <input type="checkbox"/> TIA <input type="checkbox"/> Stroke <input type="checkbox"/> Syncope <input type="checkbox"/> Murmur <input type="checkbox"/> Other _____</p> <p>Is an agitated saline contrast study required? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Is a contrast-enhanced study for quantitative LVEF required? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Is Myocardial Strain required? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>STRESS ECHOCARDIOGRAM</p> <p>CAD or R/O Ischemia Stress Echo</p> <p><input type="checkbox"/> Exercise Stress only</p> <p><input type="checkbox"/> Exercise may convert to Dobutamine</p> <p><input type="checkbox"/> Dobutamine stress only</p>	<p>Hold Beta Blocker for 24 hours prior to the test? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A</p> <p>Associated Diagnosis: _____ ICD10 _____</p> <p>Indication: <input type="checkbox"/> Chest Pain <input type="checkbox"/> Shortness of breath/ Anginal equivalent <input type="checkbox"/> Possible ACS <input type="checkbox"/> Known CAD (surveillance > 2 years)</p>



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Patient Identification

EXAM	ORDER QUESTIONS
<p>HEMODYNAMIC STRESS ECHO</p> <p><input type="checkbox"/> MR/MS/PHTN: Exercise Stress only</p> <p><input type="checkbox"/> Low Dose Dobutamine AS severity: Low Dose Dobutamine Protocol</p> <p><input type="checkbox"/> HCM Stress Echocardiogram</p>	<p>Evaluate for: <input type="checkbox"/> Coronary Artery Disease <input type="checkbox"/> Ischemia</p> <p><input type="checkbox"/> Valve Disease Severity (Hemodynamic Stress only)</p> <p><input type="checkbox"/> Pre-op Risk Stratification</p> <p>Other Instructions: _____</p>
<p>TREADMILL STRESS TEST (EKG only/ No imaging)</p> <p><input type="checkbox"/> Treadmill Stress Test</p> <p>Evaluate for:</p> <p><input type="checkbox"/> Coronary Artery Disease</p> <p><input type="checkbox"/> Heart rate / BP response</p>	<p>Associated Diagnosis _____</p> <p>ICD10 _____</p> <p>Indication: <input type="checkbox"/> Chest Pain <input type="checkbox"/> Shortness of breath</p> <p><input type="checkbox"/> Palpitations <input type="checkbox"/> Fatigue <input type="checkbox"/> Syncope <input type="checkbox"/> Arrhythmias</p> <p><input type="checkbox"/> Dizziness</p> <p><input type="checkbox"/> Other _____</p> <p><input type="checkbox"/> Hold Beta Blocker for 24 hours prior to test? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>CPEX (Cardiopulmonary Exercise Stress Test)</p> <p><input type="checkbox"/> Cardiopulmonary Exercise Stress Test</p>	<p>Associated Diagnosis _____</p> <p>ICD10 _____</p> <p>Indication: <input type="checkbox"/> Heart Failure <input type="checkbox"/> Adult Congenital Heart Disease</p> <p><input type="checkbox"/> Low Exercise Capacity</p> <p><input type="checkbox"/> Other _____</p> <p><input type="checkbox"/> ICD or Pacemaker? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Type _____</p> <p><input type="checkbox"/> Other Instructions _____</p>
<p>EKG & HEART MONITORS</p> <p><input type="checkbox"/> EKG 12-Lead</p> <p><input type="checkbox"/> Holter: 24hr _____ 48hr _____</p> <p><input type="checkbox"/> Event (30 Day)</p> <p><input type="checkbox"/> Mobile Cardiac Tele (30 Day)</p> <p><input type="checkbox"/> Mobile Telemetry (14 Day)</p> <p><input type="checkbox"/> Zio Patch: 3-7 Day _____ 8-14 Day _____</p>	<p>Associated Diagnosis _____</p> <p>ICD10 _____</p> <p>Indication: <input type="checkbox"/> Chest Pain <input type="checkbox"/> Shortness of breath</p> <p><input type="checkbox"/> Palpitations <input type="checkbox"/> Fatigue <input type="checkbox"/> Syncope <input type="checkbox"/> Arrhythmias</p> <p><input type="checkbox"/> Dizziness</p> <p><input type="checkbox"/> Other _____</p> <p>Other Instructions _____</p>

**TRANSESOPHAGEL (TEE) ECHOCARDIOGRAMS AND NUCLEAR
STRESS TEST REQUIRE A DIFFERENT ORDER FORM**

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