UNIVERSITY HOSPITAL SUNY DOWNSTATE
LICH ■ CENTRAL BROOKLYN ■ BAY RIDGE

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Cardiovascular Medicine
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Brooklyn, NY 11203

# CARDIOLOGY NON-INVASIVE IMAGING PROCEDURES REQUEST

**PATIENT INFORMATION MUST BE COMPLETED FOR ALL OUTPATIENT REQUESTS:**

Patient's Name: _____
MR #: _____
DOB: _____ N. S. _____
Height: _____ Weight: _____
Address: _____
_____
Home Phone: _____
Work Phone: _____ Cell Phone: _____
Insurance Carrier: _____
Policy ID#: _____

Physician/Service (print): _____
Address: _____
Phone: _____ Fax: _____
Pager: _____
**PHYSICIAN'S SIGNATURE (REQUIRED):**
**X** _____
Date of Request: _____

Is a pre-certification required for this patient? ❑ Yes ❑ No
If so, has a pre-certification been obtained? ❑ Yes ❑ No
Pre-certification # _____
Appointment Date & Time: _____
Appointment Given By: _____

## TESTS REQUESTED

❑ 2D-Echocardiogram (Transthoracic)
❑ Transesophageal Echo (TEE)
❑ Holter Monitor
❑ 12-Lead Electrocardiogram
❑ 24-Hour Blood Pressure
Previous studies? ❑ Yes ❑ No

## STRESS TEST

**(Check appropriate combination)**

❑ Exercise Tolerance and ECG only
❑ Exercise
❑ Persantine/Lexiscan
❑ Adenosine
❑ Dobutamine
❑ Echo
❑ Thallium (only for rest viability)
❑ Sestamibi (2-day protocol)

## DIAGNOSIS / INDICATIONS

**(Test will not be performed unless diagnosis/indication is provided. Circle the main diagnosis and check ✔ all others that apply.)**

❑ Angina
❑ Arrhythmia
❑ Bradycardia
❑ CAD (Native Vessel)
❑ s/p CABG
❑ Cardiomyopathy
❑ Chest Pain/Discomfort
❑ CHF
❑ CVA
❑ Dizziness
❑ Dyspnea on Exertion
❑ Endocarditis (Bacterial)
❑ Hypertension
❑ MI (Acute)
❑ MI (Old)
❑ Murmur
❑ MVP
❑ Pacemaker
❑ Palpitations
❑ Pericardial Effusion
❑ Pre-op CV Exam
❑ Prosthetic Valve
❑ Pulmonary HTN
❑ s/p PTCA/Stent
❑ Shortness of Breath
❑ Syncope
❑ Tamponade
❑ TIA

VALVULAR DISEASE
❑ Mitral Stenosis
❑ Mitral Regurgitation
❑ Aortic Stenosis
❑ Aortic Regurgitation

_____
_____
_____

❑ s/p AVR
❑ s/p MVR
❑ s/p Aortic Root Replacement
❑ s/p Other Non-CABG Cardiac Surgery
Specify: _____
_____
_____
_____
❑ Other Diagnoses:
_____
_____
_____

**Clinical History/Specific Information Requested:** _____
_____
_____

**Is the Patient Diabetic?** ❑ **Yes** ❑ **No** **Is the Patient Asthmatic?** ❑ **Yes** ❑ **No**

**Medications:** _____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

**12-Lead ECG:** _____
**Allergies:** _____