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Cardiology Testing Order Form

Patient Name:	DOB:	Height:	Weight:
Referring Physician:	Test Date:	Time:	
Does patient have medical insurance? ☐ Yes ☐ No	Primary Insurance	Secondary Insurance	
Preauthorization Information:			

Test Requested	Indications	
☐ **Echocardiogram**	☐ Chest Pain	☐ Murmur
	☐ Shortness of Breath	☐ Aortic Valve Disorder
	☐ Heart Failure	☐ Mitral Valve Disorder
	☐ Near Syncope/Syncope	☐ Fever
	☐ Orthostatic Hypotension	☐ PVC's
	☐ TIA/Stroke	☐ Atrial Fibrillation/Flutter
	☐ Left Ventricular Hypertrophy	☐ SVT/Cardiac Dysrhythmia
	☐ Cardiomyopathy	☐ Pre-Chemotherapy
	☐ Coronary Artery Disease	☐ Other:

Test Requested	Indications	
☐ **Exercise Treadmill (EKG only)** ☐ **Exercise Nuclear Stress** ☐ **Exercise Echocardiogram** ☐ **Adenosine Nuclear Stress** ☐ **Dobutamine Nuclear Stress** ☐ **Dobutamine Echocardiogram**	☐ Chest Pain / Angina	☐ Old Myocardial Infarction
	☐ Shortness of Breath	☐ Pre-Op
	☐ Heart Failure	☐ Other:
	☐ Coronary Artery Disease	Testing physician reserves the right to do the medically appropriate test.
	☐ Abnormal EKG	
	☐ Syncope / Near Syncope	

Test Requested	Indications	
☐ **Holter (24 – 48 Hour)** ☐ **Event Monitor (30 day)** ☐ **Continuous Cardiac Monitor (Mobile) (14 – 30 days)**	☐ Palpitations	☐ Supraventricular Tachycardia
	☐ Near Syncope/Syncope	☐ AV Block
	☐ Angina	☐ LBBB
	☐ Cardiomyopathy	☐ RBBB
	☐ Atrial Fibrillation	☐ Bradycardia
	☐ Atrial Flutter	☐ Wolff-Parkinson-White
	☐ PVC's	☐ Cardiac Dysrhythmia
	☐ PAC's	☐ Other:

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