Dermatology & Allergy Clinic- 3405 Lake Ridge Drive
Family Practice Clinic- 320 N. Grandview Ave. Suite D
Multispecialty Clinic- 1515 Delhi Street Suite 100
Nephrology & Hypertension Clinic- 1500 Delhi Street, Suite 2100
Pediatric Clinic- 1500 Delhi Street, Suite 3500

CARDIOLOGY CONSULT/PROCEDURE REQUEST FORM

Cardiologist (circle one; please base your selection on patient or provider preference):
Dr. Salaheldin Abusin Dr. Timothy Martin

What do you want?

X A consult? Please complete reason for consult at bottom of this form
YES NO

X A procedure? (Circle the procedure(s) you want performed).

- ECHOCARDIOGRAPHY (CPT: 93306)
  - Remind patient not to eat heavily within 2 hours of the test

- STANDARD EXERCISE STRESS TEST (CPT: 93015): Remember, **exercise** is the preferred method of stressing the heart (compared to pharmacological stress). Usually, the exercise is a treadmill but for those patients that cannot walk on a treadmill, the bicycle or arm crank can be arranged.
  - Remind patient to wear comfortable shoes/clothing & no large meal within 2 hrs of test.
  - Remind patient to arrive 30 minutes prior to the test.

- EXERCISE STRESS ECHOCARDIOGRAPHY (CPT: 93351-office; 93350/93016/93018 in hospital outpatient)
  - Same preparation as outlined above..

- DOBUTAMINE STRESS ECHOCARDIOGRAPHY
  - Please provide patient=s weight. WEIGHT: _____ lbs
  - Remind patient not to eat heavily within 2 hours of the test
  - **If patient is taking a β-blocker, it must be stopped at least 48 hours prior to this test. If the patient is not able to be off a β-blocker for this time frame, then do NOT order this test!**

- EXERCISE TECHNETIUM STRESS TEST (93016+93018)
  - Please provide patient=s weight. WEIGHT: _____ lbs
  - NOTHING to eat or drink within 2 hours of this test.

- ADENOSINE TECHNETIUM STRESS TEST (93016+93018)
  - Please provide patient=s weight. WEIGHT: _____ lbs
  - NOTHING to eat or drink within 2 hours of this test.
  - **Patient cannot take any theophylline or persantine containing products within 24-36 hours of this test. If patient cannot be off of these medications, do NOT order this test.**

Additional information required:

X Reason for consultation/procedure request: _____

- Physician requesting consult/procedure: _____Date of request: _____
- Patient=s name: _____DOB: _____
- Patient's phone #: _____ Alternative #: _____

❖ Please include a copy of patient's insurance information or insurance card
❖ If Prior Authorization required prior to consult/procedure, requesting provider must obtain.
PRIOR AUTHORIZATION(PA): NO YES; PA Number _____
❖ Please FAX (563-557-5560) any pertinent records (e.g., last H&P, most recent progress note with current medications, any pertinent laboratory or radiology results)