Cardiology

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Name: _____ **Company:** _____

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Special Instructions: _____

_____

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If you experience any difficulty in receiving this fax, please contact the sender.

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CARILION CLINIC

CARDIOLOGY

Serving Southwest Virginia with locations in Roanoke, Westlake, Franklin, and Salem

Patient Appointment Request Fax
Fax to: 540-985-4891

To schedule appointments by phone, please call 540-982-8204

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Date/Time of Request: _____ Insurance: _____

Patient Name _____ Date of Birth _____ Phone _____

Patient Address City State Zip

Office Appointments

- ☐ Office appt urgent (within 24-48 hours)
- ☐ Office appt within 3-4 weeks any physician
- ☐ Office appt first available w/ requested physician
- ☐ New patient Consult
- ☐ Other: _____

_____
If requesting a specific physician, please provide name.

Hospital Procedures

- ☐ Cardiac Cath
- ☐ Cardioversion
- ☐ Transesophageal Echo (TEE)
- ☐ EP Study

Please provide your contact information below and a scheduler from our office will contact you.

How should we contact you?

☐ Fax ☐ Email ☐ Phone

_____
Physician Signature - required for tests

Procedure Orders

SEND MED LIST FOR ALL PROCEDURES

- ☐ Treadmill (Exercise Tolerance Test)
- ☐ Zio Monitor XT ☐ 3-7 days ☐ 8-14 days
- ☐ Tilt Table Testing

Echo (Please select one of the following)

** Echo procedures may need a image enhancer (DEFINITY) to accurately assess
** the LV function. This is a Perflutren Lipid Microspher, not an Iodine based Contrast.
** If you have any questions please call: 540-529-0744

- ☐ Echo (2D, color flow, and doppler)
- ☐ Stress Echo (Patient must be able to walk on treadmill) with Definity if needed
- ☐ Supine Ergometer Stress Echo with Definity if needed
- ☐ Dobutamine Echo (Patient cannot walk on treadmill) with Definity if needed

☐ Nuclear Scans (Please select one of the following)

** Please refer to Nuclear Policy for Patient with 50+ BMI

- ☐ Exercise Treadmill - Cardiolite
- ☐ Lexi-Cardiolite (for patients who cannot tolerate treadmill)
- ☐ Dobutamine (for patients with asthma & severe COPD)

Please provide the following information for nuclear studies:

**Height_____ **Weight_____ Latex Sensitivity: Y___ N ___

If female:
****Bra Size:_____ LMP: _____
Hysterectomy: Y___ N___ Tubal: Y___ N___

Is an Interpreter Needed: ☐ Yes ☐ No

** Please attach all office notes, labs, EKG's and cardiac diagnostic studies.

Reason for Appointment / Test

Referring Physician Name

Your Name

Your Email Address

Your Telephone Number

Your Office Fax Number

Site Code: _____
Doc Type: _____
MPI#: _____

Appointment Date & Time: _____

Physician/Procedure: _____