Department of Radiology
Dartmouth-Hitchcock
MEDICAL CENTER

STRESS TEST REQUEST

Please complete and fax to: **(603)-640-1956**
For telephone assistance: **(603)-650-5560**

PATIENT INFORMATION

Patient Name:_____ DOB: _____/_____/_____

Special Considerations: **Height***: _____' _____" **Weight***: _____ lbs MRN:_____

- ☐ Blind
- ☐ Deaf
- ☐ Diabetic
- ☐ Disoriented
- ☐ IV
- ☐ O^2
- ☐ Pregnant
- ☐ **Precautions**
- ☐ Stretcher Needed
- ☐ Wheelchair Needed
- ☐ **Claustrophobia**

Notes: _____

_____

_____

INDICATION / REQUEST DETAILS (*Required)

ICD 10 Code*: _____ **Code Descrip.*:**_____

Reason for Exam*: _____

Other Pertinent Information: _____

Special Medical Equipment Needed*: _____

Does the patient have any of the following:

Abnormal EKG*: ☐ Yes ☐ No

Beta Block Medication*: ☐ Yes ☐ No

If Yes. Should the pt. hold it prior to the test: ☐ No Hold, ☐ 24 hour hold ☐ 48 hour hold

Diabetes*: ☐ Yes ☐ No

ICD (defibrillator)*: ☐ Yes ☐ No

LBBB (left bundle branch block)*: ☐ Yes ☐ No (**If Yes, a Regadenoson Stress is the test of choice)**

Pacemaker*: ☐ Yes ☐ No

Can the patient walk up two (2) flights of stairs at a normal pace without stopping? ☐ Yes ☐ No

Test Preference*:

☐ Nuclear Treadmill Stress Test -- ☐ ASAP ☐ Next Available

☐ Nuclear Pharmacologic Stress Test (Regadenoson) -- ☐ ASAP ☐ Next Available

*It may be necessary due to technical or clinical reasons to change the type of stress test. Please check this box if this is **not** acceptable:* ☐

REFERRING PROVIDER

Ordering Facility Name: _____

Ordering Facility Phone #: (_____) - _____ - _____ Provider Pager: _____

Ordering Provider Name (Print): _____

Ordering Provider Signature*: _____ Date: _____/_____/_____

☐ Staff Physician
☐ Resident/Other

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Please send a copy of the patient's most recent office note, EKG, and Echo Report (if applicable with all referrals). All questions must be completed before the referral is able to be scheduled.