Dartmouth Health

Cardiology Non-Invasive Appointment Request Form

Complete All Fields

Include the patient's most recent office note, EKG, and Echo Report (if applicable) with all referrals

Insurance Prior Authorization Required for all Tests Except EKG

Fax this form to the number listed with the test you are ordering. Not all tests are processed by the same office. In the case of multiple test orders, please fill out as many options as apply and send to the office scheduling the *primary* test.

Date of Referral____________________________________

Referring Provider (print)______________________________

Referring Facility/Practice____________________________

Office Phone______________________________________

Office Fax____

Contact Person_____________________________________

Provider Signature__________________________________

Patient Name______________________________________

Patient DOB_______________________________________

DHMC MRN_______________________________________

Pt.'s Primary Phone #_______________________________

Pt.'s Secondary Phone#_____________________________

Pt's Mailing Address________________________________

____

Patient's Insurance_________________________________

Insurance ID#______________________________________

Insurance Group#___________________________________

OUTPATIENT CONSULT

Phone# (603) 650-5724 (option 7) Fax# (603) 727-7433

Diagnosis____ ICD 10 Code____________________

Cardiology Consult ASAP__________ Next Available__________

EKG MONITORING

Phone# (603) 650-5724 (option 7) Fax# (603) 727-7433

Diagnosis____ ICD 10 Code____________________

Insurance Prior Authorization #_________________________________ Auth. Date Range____________________________

Does the patient have a nerve stimulator? Yes_______ No_______ If yes, please specify __________________________

EKG and Short Term Monitors:

EKG/ECG ASAP__________ Next Available__________

Holter Monitor 24 Hours _____ 48 Hours _____ ASAP__________ Next Available__________

Zio Patch ASAP__________ Next Available__________

Long Term Monitors:

30 Day Monitor ASAP__________ Next Available__________

Cardiology Non-Invasive Appointment Request Form

ECHOCARDIOGRAMS

Note: If patient is under 3 years of age, please call Pediatric Cardiology at (603) 653-9888

Transthoracic Echocardiogram **Phone# (603) 650-5724 (option 7) Fax# (603) 727-7433**

Diagnosis____ ICD 10 Code____________________

Insurance Prior Authorization #__________________________________ Auth. Date Range______________________________

Transthoracic Echocardiogram ASAP__________ Next Available_________

Is a Bubble Study Requested? Yes_____ No_____ If yes, why?____

Transesophageal Echocardiogram **Phone# (603) 650-6152 Fax# (603) 643-7352**

Note: A recent Echocardiogram report must be sent with a TEE order.

Diagnosis____ ICD 10 Code____________________

Insurance Prior Authorization #__________________________________ Auth. Date Range______________________________

Does the patient have difficulty swallowing or a history of esophageal/airway problems (OSA, COPD, etc.)? Yes _____No _____
Specify _______________________________

Is the patient's BMI over 40? Yes_____ No _____

Transesophageal Echocardiogram ASAP__________ Next Available__________

STRESS TESTING

Diagnosis____ ICD 10 Code____________________

Insurance Prior Authorization #__________________________________ Auth. Date Range______________________________

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

Can the patient walk up 2 flights of stairs at a normal pace without stopping? Yes_____ No_____

Does the patient have an ICD? Yes _____ No _____ Does the patient have a Pacemaker? Yes _____ No _____

Does the patient have a LBBB? Yes_____ No_____ *If yes, please consider a Regadenoson Stress.*

Has the patient had an abnormal EKG? Yes_____ No_____ Does the patient have Diabetes? Yes _____ No _____

Does the patient take a Beta Blocker medication? Ex: Metoprolol, Atenolol, Propranolol, Carvedilol…. Yes_____ No_____

If the patient is taking a Beta Blocker, should they hold it prior to the test? No Hold_____ 24 Hour Hold_____ 48 Hour Hold____

Does the patient have a history of A-Fib? Yes_____ No_____

Echo Lab Stress Testing **Phone# (603) 650-6152** **Fax# (603) 643-7352**

Treadmill Stress Echocardiogram ASAP__________ Next Available__________

Dobutamine Stress Echocardiogram (non-exercise) ASAP__________ Next Available__________

Stress Test, Treadmill (EKG only, no imaging) ***EKG within 12 Months Required*** ASAP__________ Next Available__________

Radiology Stress Testing **Phone# (603) 650-5560** **Fax# (603) 640-1956**

Note: Radiology will not contact patients to schedule. Please inform patient that they will have to call to schedule directly.

Nuclear Treadmill Stress Test ASAP__________ Next Available__________

Nuclear Pharmacologic Stress Test (Regadenoson) ASAP__________ Next Available__________