

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 _____

Patient Name _____

Referring Provider (print) _____

Patient DOB _____

Referring Facility/Practice _____

DHMC MRN _____

Office Phone _____

Pt.'s Primary Phone # _____

Office Fax _____

Pt.'s Secondary Phone# _____

Contact Person _____

Pt.'s Mailing Address _____

Provider Signature _____

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 Please contact First-Call Medical directly to start the enrollment process. You can complete the patient authorization form by visiting www.cognitoforms.com/FirstCallMedicalInc/securepatientauthorizationform



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 _____