



Heart and Vascular Institute of Wisconsin™

Patient Name: _____ D.O.B: _____
 Height: _____ Weight: _____
 Patient Address: _____
 Patient Phone: _____

Diagnosis(s): _____
 Ordering Provider Name: _____
 Signature: _____
 Return/Fax results/consult to: _____
 Due Date: _____

***Testing/Consult will be arranged with patient in next available spot pending preauthorization - unless otherwise indicated.

PLEASE SEND ALL INSURANCE INFORMATION and CLINIC NOTES WITH THIS REQUEST.

Consult:

Check to order	Consult To (Circle one):	Diagnosis/Reason for referral:
	Cardiology/Vascular Medicine	

Screening:

Check to order	Test	Special Instructions:
	Calcium Score (Screens for CAD)	\$25 Charge at time of exam \$25 Charge for the over read
	PV Screening - Carotid Ultrasound - Ultrasound of Abdominal Aorta - Ankle Brachial Index (ABI)	\$50 Charge at the time of exam

Stress Tests/Echocardiograms:

Check to order	Test	Special Instructions/order clarification Meds holds to consider (Circle Response)
	Treadmill Stress	On/Off (N/A) Beta-Blocker On/off (N/A) Nitrate
	Nuclear Stress	On/off (N/A) Beta-Blocker On/Off (N/A) Nitrate Treadmill vs Pharmacological
	Stress Echocardiogram	On/off (N/A) Beta-Blocker On/off (N/A) Nitrate
	Dobutamine Stress Echo	On/off (N/A) Beta-Blocker On/off (N/A) Nitrate Standard protocol (Yes/No)
	Echocardiogram (transthoracic)	Complete/Limited

EKG/Holter:

Check to order	Test	Special Instructions/order clarification: (Circle Response)
	EKG	
	Holter Monitor/Mobile Telemetry (MCT)	24 hour / 48 Hour/ 7-14 days
	Event Monitor (30 Days)	

Ultrasound:

Check to order	Test	Special Instructions/order clarification: (Circle Response)
	US Aorta	
	US Renal	
	US ABI	Right/Left/ Bilateral with/without exercise
	US Carotid Duplex	
	US Venous Duplex	Right/Left/Bilateral

X-Ray:

Check to order	Test	Special Instructions:
	Chest X-ray (2 view)	

Lab:

Check to order	Test	Special Instructions:
	CBC	
	Bmet	
	ALT	
	Magnesium	
	Lipid Panel	
	NTproBNP	
	INR	
	Potassium	
	Creatinine	
	TSH	
	Free T4	
	Ferritin	

CT:

Check to order	Test	Special Instructions/order clarification: (Circle Response)
	CT Abdomen	w/wo Contrast Last Creatinine:_____ Date_____
	CT Abdomen & Pelvis	w/wo Contrast Last Creatinine:_____ Date_____
	CT Chest r/o PE	Last Creatinine:_____ Date_____
	CT (Other): _____	Last Creatinine:_____ Date_____