

CARDIOLOGY PATIENT APPOINTMENT/CONSULTATION REQUEST FORM

**Fax completed form to the Consultation and Referral Services Center at 913-588-5785.
 For questions call 913-588-5862 or 877-588-5862.**

Kansas Office Locations		Missouri Office Locations
Kansas City The University of Kansas Hospital 3901 Rainbow Blvd, Kansas City, KS 66160	State Ave Office , 5701 State Ave. Ste. 300 Kansas City, KS 66102	Liberty 1135 W Kansas Ave Liberty, MO 64068
Overland Park 10787 Nall, #300 Overland Park, KS 66211	Lansing , 712 First Terr. #C Lansing, KS 66043	Parkville , 5501 NW 62 nd Terr, Ste 201 Kansas City, MO 64151
Atchison 1301 North 2 nd St. 2 nd Floor Atchison, KS 66002	Emporia 1301 West 12th Avenue, Suite 202 Emporia, KS 66801	St. Joseph 3915 Sherman Ave St. Joseph, MO 64506
		Hickman Mills-- 11201 Colorado Avenue Kansas City, MO 64137

Patient Name: _____ **DOB** _____
Height _____ (in.) **Weight** _____ (lbs) **Home Phone:** _____ **Alt Phone:** _____
Address: _____
Primary Insurance: _____ **Secondary Insurance** _____
Type of evaluation requested: _____ **Consult with Cardiologist** _____ **Procedure only (complete type below)**
IMMEDIATE (within 24 hours) **NO** **YES** (reason for urgency) _____ **ROUTINE** (next available) **YES** **NO**

X **DIAGNOSIS/INDICATION IS REQUIRED PRIOR TO PATIENT BEING SCHEDULED:**

Diagnosis Code (Indications): _____

Echocardiography: check all that apply

Resting Echo with Doppler
 Exercise Echo w/Doppler
 Dobutamine** Stress Echo Doppler
 Resting Echo without Doppler
 Exercise Echo (without Doppler)
 Dobutamine** Stress Echo (without Doppler)
 Bicycle Exercise Echo (complete echo w/ Doppler at rest and during exercise, PAP, valve gradients)
Specify: if to be completed with a complete resting echo _____

****Preparation for Dobutamine Stress Echo:** 4 hours prior to procedure clear liquids only: 2 hours prior to procedure no food or beverage by mouth
THIS SECTION MUST BE COMPLETED. Please check the box next to the condition as it pertains to this patient.
 Pulmonary Hypertension
 Acute pulmonary hypertension
 Acute coronary syndrome
 Serious ventricular arrhythmia
 Worsening or unstable congestive heart failure
 Respiratory failure

Peripheral Vascular Imaging: check all that apply

Carotid Duplex Scan
 Renal Artery Duplex Scan (**Patient must be NPO**)
 Abdominal Aortic Scan (**Patient must be NPO**)
 Lower Extremity **Venous** Scan (L R)
 ABI's - **ONLY**
 Lower Extremity **Arterial** Scan (L R)
 Complete Lower Arterial Duplex [incl. abi's, aorta, iliacs and both legs]) (**Patient must be NPO**)

Nuclear Imaging: check all that apply (NPO after midnight and No caffeine 24 hours before Thallium Tests)

Exercise Thallium
 Regadenoson Thallium
 Adenosine Thallium
 RVG (MUGA) Scan
 Dobutamine Thallium

Cardiac CTA : **Cardiac MRI:**

Electrocardiography: check all that apply

Resting EKG
 Event Recorder-**Please circle:** (Looping or Non-Looping)
 Tilt Table Test
 Treadmill EKG (without imaging)
 Holter Monitor (w/ interp. _____ , w/o interp. _____)

X **Ordering Physician (print)** _____ **Phone:** _____ **Fax:** _____
Ordering Physician (sign) _____ **Date** _____ **DX/INDICATION** _____
PHYSICIAN SIGNATURE AND DIAGNOSIS/INDICATION IS REQUIRED PRIOR TO PATIENT BEING SCHEDULED:

FOR CALL CENTER USE ONLY – DO NOT WRITE BELOW THIS LINE

Appointment Date: _____ Appointment Time: _____
 Physician Name: _____ Location: _____