

## Non-Invasive Cardiology Procedure Order Form

Thank you for choosing to refer your patient to the Berkeley Outpatient Center. To start the referral process, please complete this form and fax it to the corresponding fax number below.

- Physicians: for cardiology testing, fax this form to (415) 353-1784. For vascular testing, fax this form to (415) 353-2669. Physicians: for help referring a patient, call (800) 444-2559.
- Send brief, pertinent medical records, including test results and imaging that support the procedure, if available.
- Send a copy of the patient's insurance card (both sides) and HMO authorization if required.
- Patients: to schedule a cardiology test, please call (415) 353-1262.**

Date: \_\_\_\_\_ No. of pages: \_\_\_\_\_ From: \_\_\_\_\_  
To: **Berkeley Outpatient Center** Title: \_\_\_\_\_  
Fax: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

### Patient Information

Name of patient: \_\_\_\_\_ DOB: \_\_\_\_\_  
Parent or caregiver: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_  work phone  cell phone Insurance: \_\_\_\_\_

### Consulting Request Information

Diagnosis/ICD-9/10: \_\_\_\_\_  
Name of UCSF MD (if known): \_\_\_\_\_ Specialty: \_\_\_\_\_  
Reason for procedure: \_\_\_\_\_  
Is authorization required?  Yes  No If yes, authorization number: \_\_\_\_\_

### Procedure Requested

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> 12-lead electrocardiogram (ECG)          | <input type="checkbox"/> Echocardiography, 2D and 3D, with Doppler and strain  | <input type="checkbox"/> Upper extremity venous<br><input type="checkbox"/> left <input type="checkbox"/> right <input type="checkbox"/> bilateral   |
| <input type="checkbox"/> Ambulatory electrocardiography           | <input type="checkbox"/> Treadmill stress ECG  | <input type="checkbox"/> Lower extremity arterial<br><input type="checkbox"/> left <input type="checkbox"/> right <input type="checkbox"/> bilateral |
| <input type="checkbox"/> 24-hour Holter                           | <input type="checkbox"/> Treadmill stress echocardiogram   | <input type="checkbox"/> Lower extremity venous<br><input type="checkbox"/> left <input type="checkbox"/> right <input type="checkbox"/> bilateral   |
| <input type="checkbox"/> 48-hour Holter                           | <input type="checkbox"/> ABI   | <input type="checkbox"/> Graft imaging<br><input type="checkbox"/> left upper extremity<br><input type="checkbox"/> right upper extremity            |
| <input type="checkbox"/> 1- to 7-day extended Holter ("Zio")      | <input type="checkbox"/> Carotid Doppler   | <input type="checkbox"/> Abdominal aorta ultrasound  |
| <input type="checkbox"/> 7- to 14-day extended Holter ("Zio")     | <input type="checkbox"/> Renal artery Doppler  |  |
| <input type="checkbox"/> Event monitor                            | <input type="checkbox"/> Upper extremity arterial<br><input type="checkbox"/> left <input type="checkbox"/> right <input type="checkbox"/> bilateral |  |
| <input type="checkbox"/> 14 days <input type="checkbox"/> 30 days |  |  |
| <input type="checkbox"/> Telemetry                                |  |  |
| <input type="checkbox"/> 14 days <input type="checkbox"/> 30 days |  |  |

### Referring Physician Information

Referring MD: \_\_\_\_\_ Specialty: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
Primary care provider: \_\_\_\_\_ Phone: \_\_\_\_\_  
Signature: \_\_\_\_\_ Date: \_\_\_\_\_

NOTICE OF CONFIDENTIALITY: This is a confidential fax and is intended solely for the person indicated above. If you are not the intended person, you are hereby notified of the confidential nature of this fax and that you are not entitled to read, copy or otherwise disseminate any of the information contained herein.

**THIS FORM MUST BE COMPLETED AND FAXED PRIOR TO SCHEDULING.**