



Department of Cardiology

Fax# 617-376-1640

Phone Number 617-376-4040

Please fill out all pertinent information and fax to the cardiology department prior to scheduling outpatient cardiology exams over the phone. *** **Please provide original copy with general instruction for testing to patient.** ***

Patients Name:	Home Phone Number:
Date of Birth:	Work/Cell Phone Number:
Social Security Number:	Next of Kin:
Home Address:	

Ordering Physician (Please print):	National Provider Identifier (NPI)
---	------------------------------------

Please Check the Type of Test(s) Needed:

<input type="checkbox"/> Regular Exercise Stress Test	<input type="checkbox"/> Exercise Stress Echo
<input type="checkbox"/> Nuclear Medicine Exercise Stress Test	<input type="checkbox"/> Transesophageal Echo (TEE)
<input type="checkbox"/> Nuclear Medicine Pharmacologic (Persantine) Stress Test	<input type="checkbox"/> Echocardiogram with Doppler
<input type="checkbox"/> Nuclear Medicine Pharmacologic (Dobutamine) Stress Test	<input type="checkbox"/> Holter Monitoring (24 or 48 hours)
<input type="checkbox"/> Pharmacologic (Dobutamine) Stress Echo	<input type="checkbox"/> Event Monitoring (30 days)

Diagnosis / Reason for Study (No R/O or "Question of..." accepted):
Reason for Doppler (for all echocardiograms):

Pre-authorization # _____ (needed for Nuclear Medicine Stress Tests with the following insurances):

All Harvard Pilgrim Insurance Plans (even if secondary insurance)	Aetna HMO
All Tufts Insurance Plans (except for Secure Horizons)	Cigna HMO
All Blue Cross Insurance Plans (except for PPO and Federal plans)	Great West
HMO Blue (ordering office will know)	Tufts Care Link

Patient Height:	**Patient Weight:	Patient Pregnant? Y / N
Does the Patient Have a Pacemaker? Y / N	Does the Patient have a history of Diabetes? Y / N	
Latex or Other Allergies?	Language Interpreter Needed? Y / N Type?	

Physician Signature:	Date:
Office Phone #:	Send Additional Copy of Report to:

** Required

Original 03/03/07
Revised 12/3/08