TRI-CITY CARDIOLOGY

NEW CONSULT AND TESTING ORDER FORM

****PLEASE FAX ALL MEDICAL RECORDS, DEMOGRAPHICS, & COPY OF INSURANCE CARDS TO (480) 461-4243.****

PHYSICIANS AND OFFICE STAFF DIRECT LINE: (480) 993-1089

MULTIPLE CONVENIENT LOCATIONS IN MESA, GILBERT, SAN TAN VALLEY AND SCOTTSDALE INCLUDING STATE-OF-THE-ART VEIN CENTER

Cardiology	Interventional Cardiology	Interventional Cardiology & Peripheral Vascular		Electrophysiology
___ *1st Available*	___ *1st Available*	___ *1st Available*		___ *1st Available*
___ Camille Phuc Le, MD	___ Kelly Guld, MD	___ S Reddy Atmakuri, MD*	___ Jacob Green, MD	___ Jaskanwal Bisla, MD
___ Loan Nguyen, MD	___ David Kassel, MD	___ M Joshua Berkowitz, MD*	___ Duane Heinrichs, MD*	___ Arun Kolli, MD
___ Todd Perlstein, MD	___ Craig D. Robison, MD	___ Sreedivya Chava, MD	___ Jaskamal Kahlon, MD*	___ Osama T. Niazi, DO
___ Thomas Ritchie, MD		___ Joshua Cohen, MD*	___ Praneet Sharma, MD	___ Kai Sung, MD
___ Mark Stern, MD		___ James DelGiorno, MD	___ Ephraim Weiss, MD	
___ Arman Talle, MD			**Performs Venous Ablations***	

ORDERING PHYSICIAN:	
OFFICE PHONE #: ( )	**FAX #: ( ) -**
PATIENT FIRST NAME: -	**PATIENT LAST NAME:**
SOCIAL SECURITY #: -	**DATE OF BIRTH: - -**
PATIENT HOME PHONE #: ( )	**PATIENT CELL #: ( ) -**
CARDIOVASCULAR DX:	

PLEASE CHOOSE URGENCY OF APPOINTMENT :

_____ **NEXT AVAILABLE** _____ **WITHIN 2 WEEKS** _____ **WITHIN 1 WEEK** _____ **STAT**

INSURANCE PLAN: _____ **ID NUMBER:** _____

OFFICE CONTACT PERSON: _____ **DIRECT PHONE # :** _____

DO YOU REQUIRE A FOLLOW UP WITH APPOINTMENT DATE & TIME? **YES PHONE CALL / YES FAX BACK / NO CONTACT NEEDED**

IS A REFERRAL REQUIRED? (if so, please fax with this form) **YES** _____ **NO** _____

PLEASE CHOOSE FROM THE FOLLOWING :

_____ CONSULTATION (Cardiac - Vascular - Electrophysiology) **(Circle One)**
_____ ECHOCARDIOGRAM (M Mode 2D & Color Flow)
_____ CAROTID DUPLEX
_____ ABDOMINAL ULTRASOUND
_____ HOLTER MONITOR (24 hr only)
_____ 30 DAY EVENT MONITOR
_____ PACEMAKER/DEFIBRILLATOR CHECK
_____ ABI _____ REST _____ EXERCISE
_____ BILATERAL VENOUS ULTRASOUND (vein mapping)
_____ OTHER: _____

(OR) CHOOSE STRESS TREADMILL TESTING :

WEIGHT LIMIT FOR STRESS TESTING IS 300 lbs
(PT Weight & Height required for all Treadmill Testing)

WEIGHT: ___ **HEIGHT:** _____

_____ EXERCISE TREADMILL TEST (ETT)
_____ STRESS ECHOCARDIOGRAM
_____ NUCLEAR STRESS TEST/ MYOCARDIAL PERFUSION IMAGING
_____ EXERCISE (patient must be able to walk on treadmill)
_____ PHARMACOLOGIC
_____ LEXISCAN (__Low Level Exercise __No Exercise)
_____ DOBUTAMINE
_____ CARDIAC PET IMAGING