



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 AND SAN TAN VALLEY INCLUDING STATE-OF-THE-ART VEIN CENTER.

Cardiology

Interventional Cardiology

Inventional Cardiology & Peripheral Vascular

Electrophysiology

<input type="checkbox"/> 1st Available	<input type="checkbox"/> 1st Available	<input type="checkbox"/> 1st Available	*Performs Venous Ablations	<input type="checkbox"/> 1st Available
<input type="checkbox"/> Camille Phuc Le, MD	<input type="checkbox"/> Kelly Guld, MD	<input type="checkbox"/> Satya Atmakuri, MD*	<input type="checkbox"/> Duane Heinrichs, MD*	<input type="checkbox"/> Aron Kolli, MD
<input type="checkbox"/> Loan Nguyen, MD	<input type="checkbox"/> David Kassel, MD	<input type="checkbox"/> Joshua Berkowitz, MD*	<input type="checkbox"/> Jaskamal Kahlon, MD*	<input type="checkbox"/> Kai Sung, MD
<input type="checkbox"/> Todd Perlstein, MD	<input type="checkbox"/> Craig Robison, MD	<input type="checkbox"/> Sreedivya Chava, MD*	<input type="checkbox"/> Praneet Sharma, MD*	<input type="checkbox"/> Benjamin Jenny, MD
<input type="checkbox"/> Thomas Ritchie, MD	<input type="checkbox"/> Sulay Patel, MD	<input type="checkbox"/> Joshua Cohen, MD*	<input type="checkbox"/> Ephraim Weiss, MD	<input type="checkbox"/> Daniel Nguyen, MD
<input type="checkbox"/> Mark Stern, MD		<input type="checkbox"/> Jacob Green, MD		<input type="checkbox"/> Alan Lee, MD
<input type="checkbox"/> Arman Talle, MD				

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 the 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 and time?

(Please circle one) Yes, phone call / Yes, fax back / No contact needed

Is a referral required? Yes (please fax with this form) No

Please choose from the following:

Consultation - please circle (Cardiac / Vascular /
Electrophysiology)
 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)
 EKG Overread
 Other: _____

(Or) Choose Stress Treadmill Testing:

Weight limit for stress testing is 300 lbs.
(Patient 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 a treadmill)
 Pharmacologic
 Lexiscan _____ Low Level Exercise _____ No Exercise
 Dobutamine
 Cardiac PET Imaging