



743 East Beltline NE
 Grand Rapids, MI 49525
 PH: 616-301-7500

TO CANCEL A TEST PLEASE CALL 1-616-301-7500 AT LEAST 24 HOURS IN ADVANCE

| | | | |
|--|----------------------------------|----------------------|---------------|
| Patient Name: | | Date of Birth: | Today's Date: |
| Primary Insurance Information: | Secondary Insurance Information: | Office Phone No. | |
| Referring Physician (print full name): | | Physician Signature: | Fax No. |

APPOINTMENT INFORMATION:

Date: _____ Appointment Day: _____ Appointment Time: _____

PLEASE BRING THIS FORM WITH YOU ON DAY OF TEST

| | | |
|---|--|---|
| TEST ORDERED: (check ALL that apply) | | <input type="checkbox"/> CORONARY CT ANGIOGRAM |
| <input type="checkbox"/> Head (Brain) | <input type="checkbox"/> Maxillofacial | <input type="checkbox"/> (with) coronary calcium score |
| <input type="checkbox"/> Orbit | <input type="checkbox"/> Temporal Bones | <input type="checkbox"/> (with) coronary bypass graft patency |
| <input type="checkbox"/> Neck | <input type="checkbox"/> Chest | <input type="checkbox"/> (with) exclude aortic dissection |
| <input type="checkbox"/> Abdomen & Pelvis | <input type="checkbox"/> Abdomen Only | <input type="checkbox"/> (with) exclude pulmonary embolism |
| <input type="checkbox"/> Pelvis Only | <input type="checkbox"/> Cervical Spine | |
| <input type="checkbox"/> Extremity: (<i>specify</i>) | | |
| <input type="checkbox"/> Thoracic Spine | <input type="checkbox"/> Lumbar Spine | OTHER: |
| Angiography CTA | | |
| <input type="checkbox"/> Head Angiography | <input type="checkbox"/> Neck Angiography | |
| <input type="checkbox"/> Chest Angiography | <input type="checkbox"/> Abdomen Pelvis | |
| <input type="checkbox"/> With Run-off | | |
| <input type="checkbox"/> With Contrast | <input type="checkbox"/> Without Contrast | |
| <input type="checkbox"/> With & Without Contrast | | |



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INDICATION(s) FOR SCAN – CHECK ALL THAT APPLY

| | |
|--|--|
| <input type="checkbox"/> SYMPTOMS/ Indication for scan | Cardiac: <input type="checkbox"/> CORONARY ARTERY DISEASE (known) <input type="checkbox"/> STENT PATENCY – KNOWN CAD <input type="checkbox"/> ATHEROSCLEROSIS BYPASS GRAFT <input type="checkbox"/> PREOPERATIVE EVALUATION Type: <input type="checkbox"/> Cardiac Surgery <input type="checkbox"/> Non-Cardiac Surgery Type: _____ <input type="checkbox"/> ANOMALOUS CORONARY ARTERIES <input type="checkbox"/> VALVULAR HEART DISEASE (Mitral, Aortic) <input type="checkbox"/> CARDIAC MASS <input type="checkbox"/> PERICARDIAL DISEASE <input type="checkbox"/> CONGENITAL HEART DISEASE <input type="checkbox"/> PATIENT REQUEST |
|--|--|

LAB RESULTS – CREATININE OR GFR (within the past 30 days)

| | |
|---|--|
| Creatinine: _____ mg/dL <input type="checkbox"/> NA | GFR: _____ <input type="checkbox"/> NA |
|---|--|