CARDIOPULMONARY TEST REQUISITION
CARDIAC DIAGNOSTICS

Patient Name (Last, First MI):	Sex: ___ Male ___Female	Date of Birth:	Patient Phone#:

Weight:	Height:	Smoking Hx: ___Current Smoker ___Former Smoker ___Never Smoker
Ordering Physician/NP/PA (please print):	Ordering Provider Phone#	Fax results to:
Primary Insurance:	ID#:	Subscriber:
Secondary Insurance:	ID#:	Subscriber
Authorization Required? ___ Yes ____No	If authorization required, please attach copy of authorization	

Indicate diagnosis/signs/symptoms necessitating testing

	Atrial fibrillation, other persistent I48.19
	Atrial flutter, typical I48.3
	Cardiac murmur, unspecified R01.1
	Heart failure, unspecified I50.9
	Left bundle-branch block, unspecified I44.7
	Nonrheumatic aortic valve disease, unspecified I35.9
	Palpitations R00.2
	Preoperative cardiovascular clearance **Z01.810***
	Syncope and collapse R55
	Other:

***Please indicate diagnosis for planned surgery under 'Other'**

Requested Order:

	Cardiac exercise stress test	93015
	ECG/EKG, 12 lead, w/interpretation	93000
	Echo complete	93306
	Echo complete w/**bubble study**	93306
	Echo complete w/**contrast**	93306
	Echo complete w/**LV strain**	93356
	Echo limited	93308
	Event monitor	93270
	Zio cardiac monitor (**14 day**)	93246
	Zio cardiac monitor (**3 day**)	93242
	Zio cardiac monitor (**7 day**)	93242

Additional pertinent PMH:

Physician/NP/PA Signature: _____ Date: _____/_____/_____

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Hospital Use Only

Order to preauthorization review: ____/_____/_____ by: _____
Insurance verified: ____/_____/_____ by: _____
Pre-Authorization verified: _____/_____/_____ by: _____
Scheduled date: _____/_____/_____

Patient Label

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