

Today's Date: _____
Time: _____



Michigan CardioVascular
Institute

1-877-725-MCVI (6284) ♥ (989) 754-3000

MCVI Office Use Only
Scheduled Appointment

Date: _____
Time: _____
Location: _____



TESTING APPOINTMENT REQUEST FORM

Fax Testing Request Form & Patient's Insurance Card to the appropriate fax #.

Office Location Request: Saginaw Midland Bay City (Please note: Only Myocardial Perfusion Imaging, Echos, Carotid Dopplers and Holters can be scheduled in the Bay City office.)
Fax Numbers: (989) 754-3026 (989) 633-0349 (989) 671-2701

Patient Information

Name: _____
Address: _____
DOB: _____
Phone #: _____ Alt. Phone #: _____
Best Time to Contact: _____
MCVI Office Use Only
Patient Information Packet Sent On: _____
Scheduler's Initials: _____

Referring Physician Information

Physician's Name: _____
Phone #: _____
Office Contact Name: _____
Fax #: _____
(completed testing appointment request will be faxed back to you)
Physician Signature: _____

Please check as many indications as apply for the appropriate test being requested.

Myocardial Perfusion Imaging / **Treadmill Stress Test**

- Exercise OR Non-Exercise **Stress Echo**
- | | |
|---|---|
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Abnormal EKG |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Atherosclerosis |
| <input type="checkbox"/> Dyspnea | <input type="checkbox"/> History of CABG |
| <input type="checkbox"/> Palpitations | <input type="checkbox"/> History of MI |
| <input type="checkbox"/> Syncope | <input type="checkbox"/> Ischemic Heart Disease |
| <input type="checkbox"/> Pre-op Evaluation | <input type="checkbox"/> Dysrhythmia |
| <input type="checkbox"/> CHF | <input type="checkbox"/> Conduction Disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Abdominal Aneurysm |
| <input type="checkbox"/> Cardiomyopathy | <input type="checkbox"/> Carotid Artery Disease |
| <input type="checkbox"/> Valvular Heart Disease | |
| <input type="checkbox"/> Other _____ | |

Holter Monitor (24 hour) / **Event Monitor (30 days)**

- | | |
|---|--|
| <input type="checkbox"/> Cardiac Dysrhythmias | <input type="checkbox"/> Conduction Disorder |
| <input type="checkbox"/> Ischemic Heart Disease | <input type="checkbox"/> Syncope |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Palpitations |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Dyspnea |
| <input type="checkbox"/> History of MI | <input type="checkbox"/> Antiarrhythmic Medication Use |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Transient Alteration of Awareness |
| <input type="checkbox"/> Other _____ | |

T-wave Alternans

- | | |
|---|---|
| <input type="checkbox"/> Paroxysmal Ventricular Tachycardia | |
| <input type="checkbox"/> Syncope | |
| <input type="checkbox"/> Premature beats with... | <input type="checkbox"/> Palpitations with... |
| <input type="checkbox"/> Heart Failure | <input type="checkbox"/> Heart Failure |
| <input type="checkbox"/> Ischemic Heart Disease | <input type="checkbox"/> Ischemic Heart Disease |
| <input type="checkbox"/> Family History of SCD | <input type="checkbox"/> Family History of SCD |
| <input type="checkbox"/> Other _____ | |

Echo

- | | |
|---|---|
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Angina |
| <input type="checkbox"/> Dyspnea | <input type="checkbox"/> Palpitations |
| <input type="checkbox"/> Murmur | <input type="checkbox"/> Edema |
| <input type="checkbox"/> Syncope | <input type="checkbox"/> TIA |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> CHF |
| <input type="checkbox"/> Cardiomyopathy | <input type="checkbox"/> Pulmonary Hypertension |
| <input type="checkbox"/> Abnormal EKG | <input type="checkbox"/> Ischemic Heart Disease |
| <input type="checkbox"/> History of MI | <input type="checkbox"/> Conduction Disease |
| <input type="checkbox"/> Valvular Heart Disease | <input type="checkbox"/> Aortic Valve |
| <input type="checkbox"/> Mitral Valve | <input type="checkbox"/> History of Valve Replacement |
| <input type="checkbox"/> Other _____ | |

Pulmonary Function Testing

- | |
|---------------------------------------|
| <input type="checkbox"/> Dyspnea |
| <input type="checkbox"/> COPD |
| <input type="checkbox"/> Nicotine Use |
| <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Other _____ |

EECP

- | |
|--------------------------------|
| <input type="checkbox"/> _____ |
| <input type="checkbox"/> _____ |

Ambulatory BP Monitor

- | |
|--------------------------------|
| <input type="checkbox"/> _____ |
| <input type="checkbox"/> _____ |

Vascular Studies

Carotid Studies

- | |
|---|
| <input type="checkbox"/> Carotid Bruit |
| <input type="checkbox"/> Syncope |
| <input type="checkbox"/> Vertigo |
| <input type="checkbox"/> Visual Field Defect |
| <input type="checkbox"/> Paresthesia |
| <input type="checkbox"/> Pre-op CABG |
| <input type="checkbox"/> Pulsatile Tinnitus |
| <input type="checkbox"/> Speech Disturbance |
| <input type="checkbox"/> Post-op Carotid Surgery |
| <input type="checkbox"/> Sudden/Transient Visual Loss |
| <input type="checkbox"/> Ischemic Cerebrovascular Disease |
| <input type="checkbox"/> Cerebral Atherosclerosis |
| <input type="checkbox"/> Other _____ |

Peripheral Vascular Studies

- | |
|--|
| <input type="checkbox"/> Claudication |
| <input type="checkbox"/> Thrombophlebitis |
| <input type="checkbox"/> Hypercoagulopathy |
| <input type="checkbox"/> Arterial Embolism |
| <input type="checkbox"/> Arterial Thrombosis |
| <input type="checkbox"/> Peripheral Vascular Atherosclerosis |
| <input type="checkbox"/> Chronic Venous Insufficiency |
| <input type="checkbox"/> Extremity Ulceration |
| <input type="checkbox"/> Cellulitis |
| <input type="checkbox"/> Erythema |
| <input type="checkbox"/> Edema |
| <input type="checkbox"/> Other _____ |

Visceral Vascular Studies

- | |
|--|
| <input type="checkbox"/> Malignant/Accelerated Hypertension |
| <input type="checkbox"/> Vascular Insufficiency |
| <input type="checkbox"/> Arterial Bruit |
| <input type="checkbox"/> Portal Hypertension |
| <input type="checkbox"/> Thrombosis Vena Cava |
| <input type="checkbox"/> Claudication |
| <input type="checkbox"/> Reno-vascular Obstruction/Aneurysm |
| <input type="checkbox"/> Mesenteric Vascular Disease |
| <input type="checkbox"/> Abdominal Pain/Swelling |
| <input type="checkbox"/> Aneurysm |
| <input type="checkbox"/> Abdominal <input type="checkbox"/> Thoracic |
| <input type="checkbox"/> Iliac <input type="checkbox"/> Dissection |
| <input type="checkbox"/> Post-op Surgical Resection |
| <input type="checkbox"/> Other _____ |