CCT CARDIOLOGY CONSULTANTS OF TEXAS

Baylor Heart and Vascular Hospital 621 N. Hall Street, Suite 400 Dallas, Texas 75226

Appointment Request Form

Fax: 469-800-7410

Please fax with medical records and insurance information

PATIENT INFORMATION:

NAME: _____

SEX: ☐ Male ☐ Female DOB: _____ SSN: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME PH: _____ WORK PH: _____ CELL PH: _____

PRIMARY INSURANCE: _____ SECONDARY INSURANCE: _____

INSURED'S NAME: _____ DOB: _____

INSURED'S ID#: _____ GROUP#: _____

INSURANCE ADDRESS: _____ INSURANCE PH: _____

REFERRAL # VISIT: _____ HMO ☐ PPO ☐ POS ☐

CCT PHYSICIAN: _____ ** *Please fax copy of insurance card* **

REFERRING PHYSICIAN INFORMATION:

NAME: _____ CONTACT PERSON: _____

ADDRESS: _____

OFFICE PH: _____ FAX: _____

TYPE OF VISIT: ☐ Consult Only ☐ Consult/Test ☐ Testing Only ☐ Pre-op Clearance (see below)

DIAGNOSIS: _____

PROCEDURE INFORMATION *Please check requested procedure(s)*

TESTING:

☐ EKG ☐ 24-Hour Holter Monitor ☐ Stress Test ☐ Stress Echo ☐ Echocardiogram (sonogram)
☐ Event Recorder

NUCLEAR STRESS TEST (THALLIUM):

☐ Exercise ☐ Adenosine ☐ Dobutamine

Can patient walk on treadmill? ☐ Yes ☐ No

Does patient have history of asthma? ☐ Yes ☐ No

VASCULAR TEST:

Carotids _____ Arterial Pressures _____

Venous Ultra Sound (rt, lf, or Bil) _____

Other _____

☐ Pre-op Clearance

Date of surgery _____

☐ Test and consult
☐ Consult Only

** *Specify Test* **