MID-AMERICA CARDIOLOGY
THE UNIVERSITY OF KANSAS HOSPITAL

CARDIOLOGY PATIENT APPOINTMENT/CONSULTATION REQUEST FORM

Fax completed form to the Consultation and Referral Services Center at 913-588-5785.
For questions call 913-588-5862 or 877-588-5862.

Kansas Office Locations		Missouri Office Locations
Kansas City The University of Kansas Hospital 3901 Rainbow Blvd, Kansas City, KS 66160	**State Ave Office,** 5701 State Ave. Ste. 300 Kansas City, KS 66102	**Liberty** 1530 N. Church Rd., Liberty, MO 64068
Overland Park 10787 Nall, #300 Overland Park, KS 66211	**Leavenworth,** 3601 W. 4th St. Ste. #1 Leavenworth, KS 66048	**Tremont,** 5501 NW 62nd Terr, Ste 201 Kansas City, MO 64151
Atchison 820 Raven Hill Road, Ste 106A Atchison, KS 66002	**Hays** 2214 Canterbury Drive Hays, Kansas 67601	**St. Joseph** 3943 Sherman Ave St. Joseph, MO 64506

Patient Name:
_____**DOB**_____**SSN**_____

Height_____(in.) **Weight**_____(lbs) **Does pt. have central line access?** ☐ No ☐ yes, Type_____
Home Phone: _____ **Alt Phone**:_____ **Street Address**:_____
City_____ **State**_____ **Zip**_____ **Email**_____
Primary Insurance:_____**Secondary Insurance**_____

☐ **Routine** ☐ **Urgent Type of evaluation requested :** ☐**Consult with Cardiologist** ☐**Procedure only (complete type below)**

Echocardiography: check all that apply **Diagnosis Code (Indications):** _____
☐ 2D Echo + Doppler ☐ Exercise Echo + Doppler ☐ Dobutamine** Stress Echo Doppler
☐ 2D Echo **ONLY** ☐ Exercise Echo (without Doppler) ☐ Dobutamine** Stress Echo (without Doppler)
☐ Bicycle Exercise Echo (complete echo w/ Doppler at rest and during exercise, PAP, valve gradients) **Hospital Office Location Only**
Specify: if to be completed with a complete resting echo _____

Peripheral Vascular Imaging: check all that apply **Diagnosis Code (Indications):** _____
☐ Carotid Duplex Scan
☐ Renal Artery Duplex Scan **(Patient must be NPO)** ☐ Abdominal Aortic Scan **(Patient must be NPO)**
☐ Lower Extremity **Venous** Scan (L☐ R☐) ☐ ABI's – **ONLY **ABI's must be performed w/in 90 days of lower extremity imaging. (Patient must be NPO)**
☐ Lower Extremity **Arterial** Scan (L☐ R☐) ☐ Complete Lower Arterial Duplex [incl. abi's, aorta, iliacs and both legs]) **(Patient must be NPO)**

Nuclear Imaging: check all that apply (NPO after midnight and No caffeine 24 hours before Thallium Tests)
Diagnosis Code (Indications): _____
☐ Exercise Thallium ☐ Regadenoson Thallium ☐ Adenosine Thallium
☐ RVG (MUGA) Scan ☐ Dobutamine Thallium

Cardiac CTA : ☐ **Cardiac MRI:** ☐ **CT Pelvis w/wo contrast:** ☐ **CT Abdomen w/wo contrast** ☐
CT Chest with contrast: ☐ **CT Chest without contrast:** ☐ **CT Chest with and without contrast:** ☐

Electrocardiography: check all that apply
☐ Resting EKG ☐ Event Recorder-**Please circle:** (Looping or Non-Looping) ☐ Tilt Table Test
☐ Treadmill EKG (without imaging) ☐ Holter Monitor (w/ interp. _____ , w/o interp. ____)

Ordering Physician (print) _____ **Phone**:_____**Fax**:_____

X
Ordering Physician (sign) _____**Date**_____

DX/INDICATION_____

PHYSICIAN SIGNATURE AND DIAGNOSIS/INDICATION IS REQUIRED PRIOR TO PATIENT BEING SCHEDULED:

FOR CALL CENTER USE ONLY – DO NOT WRITE BELOW THIS LINE

Appointment Date: _____ Appointment Time:_____ Physician Name:_____
Location:_____

Insurance referral must be faxed to (913) 588-5785 before the appointment can be confirmed. Referrals received after 3 P.M. will be handled the next business day.