

OUTPATIENT PROCEDURES

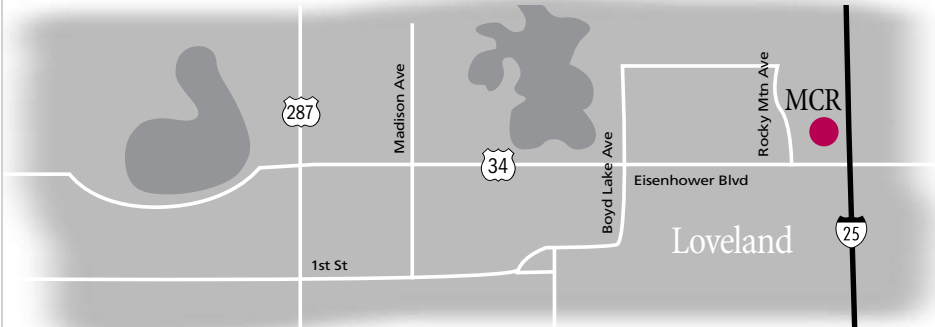
OUTPATIENT PROCEDURES		
Tests(s) Ordered -Required-	ICD-9 Code(s) -Required- <small>Medically Necessary Diagnosis</small>	
EXERCISE TREADMILL TESTS—low risk patients <input type="checkbox"/> Bruce (protocol) <input type="checkbox"/> Low Level (sub maximal)		Today's Date _____ Patient's Name _____ Date of Birth _____ Appointment Date _____ Appointment Time _____ Check-in Time _____ <input type="checkbox"/> Harmony Campus <input type="checkbox"/> PVH <input type="checkbox"/> MCR <input type="checkbox"/> Sterling <input type="checkbox"/> Estes Park <input type="checkbox"/> Greeley (Nuclear testing is only available at Harmony Campus and Medical Center of the Rockies.) Diagnosis and symptom(s) _____ _____ Referring Physician's Name _____ Referring Physician's Phone () _____ Referring Physician's Signature _____
STRESS NUCLEAR PERFUSION IMAGING - moderate to high risk patients (nuclear testing is done at either the Medical Center of the Rockies or the Fort Collins-Harmony Campus) <input type="checkbox"/> Exercise (if no LBBB on ECG, pacemaker, or defibrillator) <input type="checkbox"/> Adenosine (inability to exercise on treadmill, if no significant asthma) <input type="checkbox"/> Dobutamine Stress <input type="checkbox"/> MUGA Scan		_____ Referring Physician's Name _____ Referring Physician's Phone () _____ Referring Physician's Signature _____
CARDIAC EVENT MONITORING - <input type="checkbox"/> 24-hour Rhythm Monitor (Holter Monitor) <input type="checkbox"/> 48-hour Rhythm Monitor (Holter Monitor) <input type="checkbox"/> 30-day Event Monitor (King of Hearts Monitor)		_____ Referring Physician's Name _____ Referring Physician's Phone () _____ Referring Physician's Signature _____
CARDIOVASCULAR ULTRASOUND - <input type="checkbox"/> Adult Echocardiogram <input type="checkbox"/> Bubbles <input type="checkbox"/> Contrast <input type="checkbox"/> Pediatric Echocardiogram (Poudre Valley Hospital only) <input type="checkbox"/> Stress Echocardiogram <input type="checkbox"/> Exercise/Treadmill <input type="checkbox"/> Dobutamine <input type="checkbox"/> TEE (requires sedation) <hr style="border-top: 1px dashed black;"/> <input type="checkbox"/> Carotid <hr style="border-top: 1px dashed black;"/> <input type="checkbox"/> Venous Duplex <input type="checkbox"/> Lower Ext <input type="checkbox"/> Upper Ext <input type="checkbox"/> Both <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Vein Mapping (for CABG) <hr style="border-top: 1px dashed black;"/> <input type="checkbox"/> Arterial Duplex/Lower <input type="checkbox"/> Both <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> ABI Only <input type="checkbox"/> PPG <input type="checkbox"/> Arterial Duplex/Upper <input type="checkbox"/> Both <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Allen's Test <input type="checkbox"/> PPG <input type="checkbox"/> Assess AV Fistula (includes PPG)		_____ Referring Physician's Name _____ Referring Physician's Phone () _____ Referring Physician's Signature _____ <i>All tests will be scheduled as routine unless otherwise specified.</i> STAT fax report Yes No Fax No. () _____ STAT call report Yes No Phone No. () _____ Patient preparation form given? Yes No <i>Please note: Patient will follow up with referring physician for test results unless a cardiology consult is requested for patient education related to these results.</i>

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Expertise in Matters of the Heart