

NUCLEAR CARDIOLOGY ORDER FORM

Patient Name: _____ Patient Phone Number: _____
 Address: _____ DOB: _____
 MRN: _____ Physician: _____ Date of Service: _____
 Office contact person: _____ Phone Number: _____

Please make sure that all order requirements are met before sending order or scheduling patients.

ORDER FORM REQUIREMENTS

- Patient & physician information is clearly legible
- Test type & diagnosis are clearly selected
- Attach your most recent clinic note so that we can best serve your patient
- Make certain that TKC Nuclear Cardiology Prep instructions are given to the patient
- Fax or email this order form to Medicine Scheduling (Fax 205.801.8107, Email domoutsiderorders@uabmc.edu)
- Schedule the patient via Medicine Scheduling by calling 205.801.5655
- Patient weight _____
 (If your patient is over 350 pounds, please contact UAB Nuclear Medicine at 205 975-8326 for scheduling.)

ORDERABLE STUDIES

<input type="checkbox"/> Myocardial Perfusion Stress Study <input type="checkbox"/> Exercise (Treadmill) (GMI) <input type="checkbox"/> Chemical (Regadenoson or Dobutamine) (LEX)	<input type="checkbox"/> Cardiopulmonary Stress Test <input type="checkbox"/> Metabolic Stress Test (MST)-Cardiology <input type="checkbox"/> Pulmonary Gas Exchange (PGE)-Pulmonary (Fax order form to 205-801-8231.)
<input type="checkbox"/> MUGA Resting Equilibrium Radionuclide Angiogram (MUG)	
<input type="checkbox"/> Cardiac Amyloid Study (Tc-99m PYP Imaging) (CAS)	<input type="checkbox"/> Myocardial Viability Study (VIA)
<input type="checkbox"/> Myocardial Perfusion Resting Study (PRO)	<input type="checkbox"/> GXT without Imaging (GXT)

DIAGNOSIS

<input type="checkbox"/> Abnormal EKG	<input type="checkbox"/> CHF new onset
<input type="checkbox"/> Ventricular Tachycardia	<input type="checkbox"/> Ischemic Heart Disease
<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Myocardial Infarction History
<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Post CABG
<input type="checkbox"/> Syncope	<input type="checkbox"/> Post CABG greater than 5 years
<input type="checkbox"/> Chest Tightness	<input type="checkbox"/> Post CABG with incomplete revascularization
<input type="checkbox"/> Coronary Artery Disease	<input type="checkbox"/> Preop Liver/Kidney Transplant
<input type="checkbox"/> Asymptomatic with high CAD risk	<input type="checkbox"/> Preop Surgery
<input type="checkbox"/> Asymptomatic with high calcium score	<input type="checkbox"/> Abnormal Treadmill Stress Test
<input type="checkbox"/> Cardiomyopathy	Other: _____
<input type="checkbox"/> CHF	_____

 Physician/Provider Signature Date