



KENTUCKY CARDIOLOGY, PLLC

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Spect/PET Order Form

Patient Name _____ D.O.B. _____

Patient Weight _____ Patient Height _____

Please check mark the appropriate stress test to be performed.

- | | |
|---|--|
| <input type="checkbox"/> Lexiscan or Persantine Myoview (78452) | <input type="checkbox"/> GXT Myoview (78452) |
| <input type="checkbox"/> Dobutamine Myoview (78452) | <input type="checkbox"/> GXT (No Imaging) |
| <input type="checkbox"/> Cardiac PET(78492) | |

Debility: _____ (must have reason if patient cannot on the walk the treadmill)

Please check mark all appropriate diagnoses.

- | | |
|--|---|
| <input type="checkbox"/> Abnl EKG | <input type="checkbox"/> Left Heart Failure |
| <input type="checkbox"/> Angina-Unstable | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> CAD | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Syncope |
| <input type="checkbox"/> CHF-Unspecified | <input type="checkbox"/> Pre-Op Clearance |
| _____ | <input type="checkbox"/> BMI of 40 or greater |

**Not all diagnosis above are payable alone. For example, pre-op clearance must be accompanied with another medical problem or risk factor.

The ordering physician's office is responsible for obtaining a precertification for this test.

Insurance Company _____

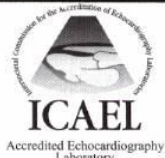
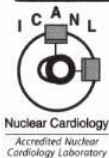
Insurance Co. Precert Phone # _____

Name of Insurance Representative spoken to _____

Authorization # _____ dates valid __/__/__ to __/__/__

Ordering physician's signature _____

We cannot accept this order unless it is completely filled out. Please fax this order to (859) 276-6364. All orders not filled out properly will be faxed back for completion.



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Lexington, Kentucky 40509

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Fax 859.226.0041