

Time: _____

PATIENT HISTORY/TEST INDICATION: Please indicate if any of the following exist.

☐ Greater than 10% on Framington Risk Score☐ Chest Pain ☐ Valvular Disease

☐ Palpitations ☐ Valve Replacement: ☐ Mechanical

II ☐ Syncope ☐ Tissue

☐ Shortness of Breath ☐ Aortic Valve Replacement

A ☐ Hypertension ☐ Mitral Valve Replacement

es ☐ Congestive Heart Failure ☐ Pacemaker: ☐ Single Chamber

rophic Cardiomyopathy ☐ Dual Chamber

ate/Severe Asthma ☐ ICD

to do treadmill ☐ PCI: Artery if known: _____

CARDIOLOGY TESTING AVAILABLE ☐ Urgent ☐ Testing Only

PHYSICIAN MEDICINE SERVICES	☐ Holter Monitor
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☐ Echocardiogram

tine Myoview MPI – <i>Asthma contraindication</i>	
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☐ Dobutamine Stress Echocardiogram

Left Ventricular Function (MUGA) ☐ Treadmill Stress Test

(LBBB contraindicated tests)

NOTE: A requisition for Diagnostic Imaging is valid at any hospital or licensed imaging facility.

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