### Appointment Date:

**LOCATION:** ___________________

**E**

**Cardiac CTA**

**Diagnosis Code (Indications):** Nuclear Imaging

**Peripheral Vascular Imaging:** check all that apply

**Diagnosis Code (Indications):**
- Carotid Duplex Scan
- Renal Artery Duplex Scan (Patient must be NPO)
- Lower Extremity Venous Scan (L □ R □)
- Lower Extremity Arterial Scan (L □ R □)
- Complete Lower Arterial Duplex [incl. aub's, aorta, iliacs and both legs] (Patient must be NPO)
- Abdominal Aortic Scan (Patient must be NPO)
- ABI's – ONLY **ABI's must be performed w/in 90 days of lower extremity imaging. (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
- RVG (MUGA) Scan
- Regadenoson Thallium
- Dobutamine Thallium
- Adenosine Thallium

**Cardiac CTA:** □ Cardiac MRI: □ CT Pelvis w/o contrast: □ CT Abdomen w/o contrast:

**CT Chest with contrast:** □ CT Chest without contrast: □ CT Chest with and without contrast:

**Electrocardiography:** check all that apply

- Resting EKG
- Treadmill EKG (without imaging)
- Event Recorder: Please circle: (Looping or Non-Looping)
- Tilt Table Test
- Holter Monitor (w/ interp. _____, w/o interp. _____)

**Ordering Physician (print)_________________________ Phone: __________________ Fax: __________________**

**Ordering Physician (sign)_________________________ Date __________________**

**DX/INDICATION**

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

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**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.