Non-Invasive Cardiology Procedure Order Form

Thank you for choosing to refer your patient to the UCSF and John Muir Health Berkeley Outpatient Center. To start the referral process, please complete this form and fax it directly to the clinic.

- Fax this form to (510) 985-5202.
- Send brief, pertinent medical records, including test results and imaging that support the procedure if available.
- Send a copy of the patient's insurance card (both sides) and HMO authorization if required.
- For help referring a patient, call (800) 444-2559.

Date: From:

No. of pages: Title:

To: **Berkeley Outpatient Center** Phone:

Fax: **(510) 985-5202** Fax:

PATIENT INFORMATION

Name of patient: DOB:

Home phone: ☐ Work phone ☐ Cell phone

Parent or caregiver:

Address:

City: State: Zip:

Insurance:

CONSULTING REQUEST INFORMATION

Diagnosis/ICD-9/10:

Name of UCSF MD (if known): Specialty: **Cardiology**

Reason for procedure:

Is authorization required? ☐ Yes ☐ No If yes, authorization number:

THIS FORM MUST BE COMPLETED AND FAXED TO BERKELEY OUTPATIENT CENTER CARDIOLOGY PRIOR TO SCHEDULING

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PROCEDURE REQUESTED

- Electrocardiography
- Ambulatory electrocardiography
  - 24-hour Holter
  - 48-hour Holter
  - 1 to 7-day extended Holter (“Zio”)
  - 7 to 14-day extended Holter (“Zio”)
  - Event monitor
  - Telemetry
- Echocardiography, 2D and 3D, with Doppler and strain
- Treadmill stress ECG
- Stress echocardiogram
- ABI
- Carotid Doppler
- Renal artery Doppler
- Upper extremity arterial
  - left
  - right
  - bilateral
- Upper extremity venous
  - left
  - right
  - bilateral
- Lower extremity arterial
  - left
  - right
  - bilateral
- Lower extremity venous
  - left
  - right
  - bilateral
- Graft imaging
  - left upper extremity
  - right upper extremity
- Abdominal aorta ultrasound

REFERRING PHYSICIAN INFORMATION

Referring MD: Specialty:

Phone: Fax:

Primary care provider: Phone:

Signature:

JOHN MUIR HEALTH | UCSF Health