KENTUCKY CARDIOLOGY, PLLC

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TESTING ORDER FORM

Patient Name_____ D.O.B._____

Patient Weight _____ Patient Height _____

Please check mark the appropriate test to be performed. Payable diagnosis is required.

____Nuclear Chemical Stress Test(78452) Dx: _____Debility:_____

____Nuclear GXT Stress Test (78452) Dx:_____

____GXT (no imaging) Stress Test Dx:_____

____Cardiac PET Stress Test (78492) Dx:_____Debility:_____

____Echocardiogram(93306) Dx:_____

____Abdominal Ultrasound Dx:_____

____Renovascular Study Dx:_____

____Superior Mesenteric Study Dx: _____

____Carotid Duplex Dx:_____

____Arterial Duplex (upper or lower) Dx:_____

____Venous Duplex (lower Extremities) Dx:_____

____24 Hour Holter Monitor Dx:_____

____30 Day Event Recorder Dx:_____

The ordering physician's office is responsible for obtaining insurance prior authorization for these tests.

Insurance Company _____ ID#_____

Prior Authorization# _____ Valid____/____/____ - ____/____/____

Ordering Physician's Name_____

Ordering Physician's Signature___ _____

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