

Patient Details

Name: _____

DOB: ____/____/____

Date: ____/____/____

CT SCAN

- | | |
|---|--|
| <input type="checkbox"/> CTA Neck w/Contrast - 70498 | <input type="checkbox"/> CCTA TAVR Protocol w/Contrast - 75574 |
| <input type="checkbox"/> CTA Chest-Aortic w/ Contrast - 71275 | <input type="checkbox"/> CTA Abd/Pelvis w/Contrast - 75635 |
| <input type="checkbox"/> Cardiac Chest-PE w/contrast- 71275 | <input type="checkbox"/> CCTA - Cardiac CTA w/contrast - 75574 |
| <input type="checkbox"/> Cardiac Calcium Score - 75571 | <input type="checkbox"/> Valve Protocol |
| <input type="checkbox"/> CCTA- Coronary CTA w/contrast 75574 | <input type="checkbox"/> Stroke Protocol |
| <small>- Includes CT FFR (Heart Flow) if clinically necessary - 0501T</small> | <input type="checkbox"/> Pulmonary veins |
| <input type="checkbox"/> CCTA - CABG Protocol w/contrast - 75574 | <input type="checkbox"/> TricValve Protocol |
| <input type="checkbox"/> CTA - Congenital w/contrast - 75573 | <input type="checkbox"/> Mass Protocol |
| | <input type="checkbox"/> LAA Protocol |
| | <input type="checkbox"/> Other _____ |

REASON(S) FOR EXAM — PLEASE CHECK ALL THAT APPLY

- | | | |
|--|--|--|
| Other: _____ | <input type="checkbox"/> I25.2 Old MI | <input type="checkbox"/> I35.9 Aortic valve disorder |
| _____ | <input type="checkbox"/> I25.5 Ischemic cardiomyopathy | <input type="checkbox"/> I48.0 Paroxysmal atrial fibrillation |
| _____ | <input type="checkbox"/> I42.9 Cardiomyopathy | <input type="checkbox"/> I71.21 Aneurysm of the ascending aorta |
| _____ | <input type="checkbox"/> I50.40 Systolic and diastolic CHF | <input type="checkbox"/> Q21.9 Congenital Septal Defect (ASD, VSD) |
| _____ | <input type="checkbox"/> I50.810 Right heart failure | <input type="checkbox"/> Q23.9 Congenital malformation of aortic and mitral valves |
| _____ | <input type="checkbox"/> I50.30 Diastolic CHF | <input type="checkbox"/> Q24.5 Malformation of coronary vessels |
| <input type="checkbox"/> I20.8 Angina pectoris | <input type="checkbox"/> I11.9 HTN with LVH w/o CHF | <input type="checkbox"/> Q24.9 Congenital malformation of heart, unspecified |
| <input type="checkbox"/> R06.02 Dyspnea | <input type="checkbox"/> I25.799 CAD with CABG with chest pain | <input type="checkbox"/> R94.31 Abnormal EKG |
| <input type="checkbox"/> R07.9 Chest pain | <input type="checkbox"/> I25.810 CAD with CABG w/o chest pain | <input type="checkbox"/> R94.39 Abnormal result of other cardiovascular function study |
| <input type="checkbox"/> I25.10 CAD w/o chest pain | <input type="checkbox"/> I25.9 Chronic ischemic heart disease | <input type="checkbox"/> D15.1 Cardiac Mass |
| <input type="checkbox"/> I25.119 CAD with chest pain | <input type="checkbox"/> I27.0 Pulmonary hypertension | |
| | <input type="checkbox"/> I31.9 Disease of pericardium | |
| | <input type="checkbox"/> I34.9 Mitral valve disorder | |

CT Coronary Angiography Preparation

Outpatient Pre-Medication Instructions for Heart Rate Lowering: BUN/CREATININE <90days Value: _____ Date: ____/____/____

- | | |
|--|--|
| <input type="checkbox"/> Take Ivabradine (Corlanor) _____mg 3 hours before CT scan.
(Prescription Given) | <input type="checkbox"/> Medications to HOLD:
_____ |
| <input type="checkbox"/> Take Metoprolol _____mg 4 hours before the CT scan.
(Prescription Given Home Medication) | _____ |
| <input type="checkbox"/> Take _____mg 4 hours before the CT scan
(Home Medication) | <input type="checkbox"/> Take Iodine/Shellfish allergy Protocol as prescribed. |
| <input type="checkbox"/> Take _____mg 4 hours before the CT scan
(Prescription Given) | 1. Prednisone 50mg: Taken 13 hours, 7 hours and 1 hour before contrast media injection (Total 3 doses) |
| | 2. Benadryl 50mg: Taken 1 hour before contrast media injection |

..... Special Instructions

- Arrive 15-30 minutes early for your appointment.
- If applicable, take heart rate lowering medication as directed.
- If you have had lab work done within 30 days of your scheduled date, please bring a copy with you to the office at the time of your appointment. (Lab results must include BUN and Creatinine Levels)
- If you have NOT had labs done within 30days of your appointment, you are responsible for getting them done. We Will provide you a lab script to get done at your preferred lab.
- NO lotions, jewelry, or wire undergarments.
- NO caffeine or decaf for 12 hours prior! (NO coffee, tea, chocolate, etc...)
- NO food or drink 3 hours prior. (Water is fine.)

CC: Referred By Physician:

CC: Other Physician:

Signature: