

## 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.<br>(Prescription Given)          | <input type="checkbox"/> Medications to HOLD: _____  |
| <input type="checkbox"/> Take Metoprolol _____mg 4 hours before the CT scan.<br>(Prescription Given Home Medication) | _____  |
| <input type="checkbox"/> Take _____mg 4 hours before the CT scan<br>(Home Medication)                                | <input type="checkbox"/> Take Iodine/Shellfish allergy Protocol as prescribed.                         |
| <input type="checkbox"/> Take _____mg 4 hours before the CT scan<br>(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:



## C. Alberto Morales M.D.

Board Certified, Cardiovascular Diseases  
Board Certified, Internal Medicine  
Board Certified, Echocardiography  
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## Program Overview

Cardiac CT Angiography (CCTA) is a non-invasive test that uses a CT scanner to see the blood flow in the arterial vessels throughout the chest. It enables the physician to look for blocked arteries in the heart using these images. Our goal is to provide advanced technology in cardiac diagnostic imaging as well as premium care for our patients. In order for us to achieve this goal in the most efficient manner, we would like you to review the following **information necessary to schedule** a patient for this procedure.

**To schedule, call our office at 813-870-1747 and Fax order form to 813-343-6089**

### **Please Fax the following information for each patient:**

- o **Order for testing requested**
- o **Enter diagnosis/indications and/or reason for study**
- o **Demographic Information (Including insurance if using insurance\*)**
- o **Recent Office Visit Note**
- o **Current Medication List**
- o **Current/Most recent vital signs/BUN and Creatinine Results**

\*There is a CASH PAY option available for \$400.00. If this is the option the patient chooses, please indicate CASH PAY on the paperwork faxed over.

**Intravenous contrast is used during this procedure. It is CRITICAL to know if the patient has any allergies to contrast.** If the patient has known renal impairment or is at risk for renal impairment, a serum creatinine should be drawn no more than two weeks prior to the procedure.

It is also important to note that if the patient is on any oral diabetic agents that contain Metformin, it will need to be held the day of the procedure and for two days after the procedure. The patient's physician will be responsible for monitoring any diabetic related issues.

**For this test to be performed, the patient's heart rate should optimally be below 60 beats per minute and regular.**

<u>Pre-Medication Instructions for Heartrate:</u> <ul style="list-style-type: none"><li>○ &gt;75: Corlanor 7.5mg (x2) and Toprolol XL 75mg (x1)</li><li>○ 66-75: Corlanor 7.5mg (x2) and Toprolol XL 50mg (x1)</li><li>○ 50-65: Corlanor 7.5 mg (x2) and Toprolol XL 25mg (x1)</li><li>○ &lt;50: No Meds Needed</li></ul> Take Medications 3-4 hours prior to CCTA	<u>Iodine Allergy Instructions:</u> <ul style="list-style-type: none"><li>○ Prednisone 50mg: take 1 tablet 13 hours prior, 1 tablet 7 hours prior and 1 tablet 1 hour prior to contrast medica injection</li><li>○ Benadryl 50mg: take 1 hour prior to contrast media injection</li></ul>
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Thank you for your cooperation and assistance with this process.

If you have any questions, please feel free to contact the office at 813-870-1747. If no answer, please leave a message and they will return your call.

Sincerely,

A handwritten signature in black ink, appearing to read 'C. Morales', with a stylized flourish.

C. Alberto Morales-Pabon MD