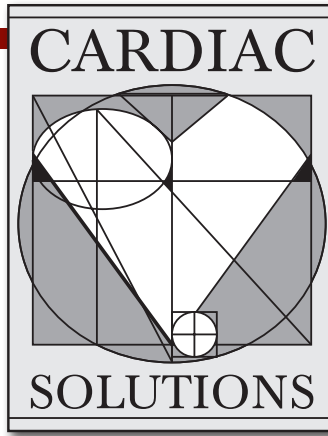


Joseph Caplan, MD, FACC
 Gabor Jilly, MD, FACC
 Vishal Patel, MD, FACC
 Manoj Rawal, MD, FACC
 Christopher Mackey, DO
 Jesse Sethi, MD, FACC, EP
 Jeffrey Greenberg, MD, FACC
 Anthony E. Sandoval, MD, FACC

Talavi Corporate Center
 5651 Talavi Blvd #160 • Glendale

Del Webb Medical Bldg. A
 14420 W. Meeker Blvd. #305 • Sun City West



Pranav Patel, DO
 Patrick Quinn, DO
 Murli Raman, MD, FACC
 Fredric Klopff, MD, FACC
 Rajeev Garg, MD, FACP, FSCAI
 Rajkumar Sugumaran, MD
 Marc Kates, DO, FACC
 Paul D. Haas, MD

Plaza Del Rio
 13128 N. 94th Dr. #100 • Peoria

Rancho Santa Fe Medical Center
 13065 W. McDowell Rd. #C-105 • Avondale

Phone: 623.876.8816

Scheduling Fax: 623.933.6739

Please fax the completed request form to our office and we will contact your patient to schedule an appointment. For urgent requests, phone our office. Inform the operator you are calling from a physician's office to schedule cardiac testing. You will then be transferred to the scheduling desk.

Patient Information

Patient Name _____ D.O.B. _____

Patient Phone _____ Insurance _____

Requesting Physician _____ (please print)

GENERAL CARDIOLOGY TESTING

Please Indicate Appropriate Diagnosis for Each Test

CARDIAC CONSULTATION

<input type="checkbox"/> New Patient Consult Diagnosis: _____	<input type="checkbox"/> Surgical Clearance _____
<input type="checkbox"/> New Patient Consult with Testing Diagnosis: _____	<input type="checkbox"/> Testing Only Diagnosis: _____

ELECTROPHYSIOLOGY CONSULTATION

<input type="checkbox"/> New Patient Consult Diagnosis: _____	<input type="checkbox"/> Atrial Fibrillation Ablation Consult Diagnosis: _____
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ULTRASOUND

<input type="checkbox"/> Echocardiogram Diagnosis Murmur, Atrial Fibrillation, Valve Regurgitation, Coronary Artery Disease, Hypertension, Cardiomyopathy, CHF, Other: _____	<input type="checkbox"/> Carotid Doppler Diagnosis Bruit, Syncope, Dizziness, Other: _____
<input type="checkbox"/> Abdominal Aorta (must be fasting for four hours) Diagnosis AAA, Atherosclerosis, Other: _____	<input type="checkbox"/> Venous Doppler Diagnosis Edema, Pain, DVT, Other: _____
	<input type="checkbox"/> Arterial Doppler Diagnosis: _____

Patient Information

Patient Name _____ D.O.B. _____

Patient Phone _____ Insurance _____

Requesting Physician _____ (please print)

Phone: 623.876.8816

Scheduling Fax: 623.933.6739

Please fax the completed request form to our office and we will contact your patient to schedule an appointment. For urgent requests, phone our office. Inform the operator you are calling from a physician's office to schedule cardiac testing. You will then be transferred to the scheduling desk.

Please Indicate Appropriate Diagnosis for Each Test

VENOUS INSUFFICIENCY CONSULTATION

New Patient Consult

Diagnosis: _____

NUCLEAR TESTING

Myoview Stress Test

Diagnosis (Chest Pain, Abnormal ECG, Shortness of Breath, S/P, PTCA/CABG, Coronary Artery Disease, Atrial Fibrillation, Syncope, Arrhythmia, Other) _____

Persantine Myoview (Chemical Stress Test)

Diagnosis (Chest Pain, Abnormal ECG, Shortness of Breath, S/P, PTCA/CABG, Coronary Artery Disease, Atrial Fibrillation, Syncope, Arrhythmia, Other) _____

Patient Weight (required for scheduling) _____

Ordering Physician Signature _____

MUGA Scan

Diagnosis (Cardiomegaly, Cardiomyopathy, CHF, Other) _____

CARDIOLOGY TESTING

Treadmill Stress Test

Diagnosis: (Chest Pain, Arrhythmia, Heart Failure, Palpitations, Syncope, Angina, Other) _____

Resting EKG

Diagnosis: (Chest Pain, Arrhythmia, Heart Failure, Palpitations, Syncope, Angina, Other) _____

24/Hour Holter Monitor

Diagnosis: (Chest Pain, Arrhythmia, Dizzy/Lightheaded, Palpitations, Syncope, Other) _____

Event Recorder

Diagnosis: (Arrhythmia, Dizzy/Lightheaded, Heart Failure, Palpitations, Syncope, Angina, Other) _____

Pacemaker Evaluation

Diagnosis: (Chest Pain, Arrhythmia, Heart Failure, Palpitations, Syncope, Angina, Other) _____

Enhanced External Counter Pulsation Therapy (EECP)

Diagnosis: _____