



CORONARY CALCIUM SCORE REQUEST FORM

Patient's Name: _____ MR #: _____

Patient's Phone: _____ Date of Birth: _____ Weight: _____

Medical Insurance: _____ Policy #: _____

Referring Physician: _____ Phone: _____ Fax: _____

Indication(s):

<input type="checkbox"/> Chest Pain /Angina	<input type="checkbox"/> Chest Pain with Atypical Features
<input type="checkbox"/> Shortness of Breath/Dyspnea	<input type="checkbox"/> Acute Coronary Syndrome
<input type="checkbox"/> Positive or Equivocal Stress Test	<input type="checkbox"/> Known Coronary Artery Disease
<input type="checkbox"/> Recent Myocardial Infraction	<input type="checkbox"/> Old Myocardial Infarction
<input type="checkbox"/> Prior Coronary Stent/Angioplasty	<input type="checkbox"/> Prior Coronary Artery Bypass
<input type="checkbox"/> Abnormal ECG	<input type="checkbox"/> Atrial Fibrillation
<input type="checkbox"/> Other _____	

Requirements for Scheduling: **Please fax a copy of the following if available:**

Progress Note Echo Stress test Cardiac Cath CT/MRI Scan

	YES	NO
History of prior coronary angiography and/or cardiac surgery?	_____	_____
If "Yes", please describe: _____		
Prior imaging study employing iodinated contrast media?	_____	_____
History of allergy or adverse reaction to iodinated contrast media?	_____	_____
If "Yes", please describe: _____		
Is the patient diabetic?	_____	_____
If "Yes", please list current diabetic medications: _____		

Does the patient have asthma or other reactive airway disease?	_____	_____
Is the patient currently in atrial fibrillation?	_____	_____
For a woman of childbearing age, is the patient pregnant?	_____	_____

Referring Physician's Signature: _____ **Date:** _____