

CT Coronary Angio Form

Office / patient demographics

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FAX COMPLETED FORM TO 860-783-5784 INCLUDING:

Clinical information (office notes, labs, med list, test results i.e. – echo, stress, angio) Please include a list of medications and pertinent information from the patients records (ex: EKG results) _____ Patient's DOB: ____ Patient's Weight: ______ lbs Patient's Height: _____ Patient's Resting Heart Rate: ______ Please Note: *** For a heart rate over 65, please give beta blockers with instructions (typically we recommend 50mg Lopressor)*** (50mg at bedtime the night prior to exam and 50 mg 2 hours prior to exam)*** MUST BE ORDERED BY REQUESTING MD Patients who are 65 + or have renal issues or are diabetic require a serum Creatinine to be drawn less than 90 days prior to scan with results faxed to us at 860-783-5784 Patients must be able to lift and rest arms up over their head for the scan History of atrial fibrillation Does the pt have allergies to medication/latex? Ν Is patient allergic to contrast dye? Diabetic (if yes, what meds) Please circle if on oral hypoglycemic (these meds must be held 2 days prior to exam): Glucophage, Metformin, Glucovance, Vandomet, Metaglip Current Previous Never Smoker (please circle) Patient takes Viagra/Levitra/Cialis Asthma (if yes, list meds)

Does the patient have known heart disease? Ν If yes, please check: 🗖 Heart attack 🚨 Coronary bypass 🗖 Stent 📮 Heart artery blockage 🗖 Heart failure 📮 Valve problems 🗖 Aortic valve problems \square Other ☐ Yes Is the patient on cholesterol lowering medicine? ■No Blood pressure medicine? ☐ Yes ☐ No How long ago? ☐ Less than 2 months ☐ Less than 1 year ☐ More than 1 year

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Yes ☐ No Daily aspirin?

History of Heart Disease

Pacemaker (if yes, please refer pt to HH)

Kidney Disease (if dialysis, please note)

Multiple Myeloma or Sickle Cell Anemia

History of Aortic Valve problems

History of Significant Aortic Stenosis