



SCHEDULING@CARDIACSOLUTIONS.NET
DIRECT MESSAGE: CARDIACSOLUTIONS@157.DIRECT.EZ.ACCESS.COM

PLEASE FAX THIS COMPLETED FORM TO OUR OFFICE AND WE WILL CONTACT YOUR PATIENT TO SCHEDULE AN APPOINTMENT.

PATIENT INFORMATION

NAME: _____

INSURANCE: _____

PHONE: _____

REFERRING PROVIDER: _____

D.O.B: _____

Routine Scheduling

STAT Scheduling
(5 Business Days)

PLEASE INDICATE APPROPRIATE DIAGNOSIS FOR EACH

PHYSICIAN CONSULTATIONS

Cardiology Consult

DIAGNOSIS: _____

EP Consult

DIAGNOSIS: _____

Vascular Consult

DIAGNOSIS: _____

Hypertension Consult

DIAGNOSIS: _____

ULTRASOUND TESTING

Echocardiogram

DIAGNOSIS: _____

Venous Doppler

DIAGNOSIS: _____

Carotid Doppler

DIAGNOSIS: _____

Arterial Doppler

DIAGNOSIS: _____

Abdominal Aorta (must fast 4 hours prior)

DIAGNOSIS: _____

Bilateral Left Right

NUCLEAR TESTING

Nuclear Stress Test

DIAGNOSIS: _____

Regular Treadmill Stress Test

DIAGNOSIS: _____

Chemical Stress Test

DIAGNOSIS: _____

Cardiac PET Testing

DIAGNOSIS: _____

PATIENT WEIGHT: _____ (required for scheduling)

BACK OFFICE TESTING

Pulmonary Function Test

DIAGNOSIS: _____

Holter Monitor

DIAGNOSIS: _____

ECAT Monitor

DIAGNOSIS: _____

Sleep Study

DIAGNOSIS: _____

ABI

DIAGNOSIS: _____

PLAZA MEDICAL CENTER
13460 N. 94TH DR J-1
PEORIA, AZ 85381

DEL WEBB MEDICAL
14420 W. MEEKER BLVD A-305
SUN CITY WEST, AZ 85375

TALAVI CORPORATE CENTER
5651 W TALAVI BLVD #160
GLENDALE, AZ 85306

WEST 101 GATEWAY
9520 W PALM LANE #150
PHOENIX, AZ 85037

