



REQUEST FOR CARDIAC CT ANGIOGRAPHY

Patient Name: _____ E-mail address: _____

Phone Number: _____ Cell Phone Number: _____

Physician Name: _____ Phone # _____

Physician Signature: _____

*****If your patient has a pacemaker we cannot do a Cardiac CT*****

Reason for Exam: _____

ICD 9 Code: _____

- If patient is over the age of 50:

BUN _____ Creatinine _____ (Results must be within 14 days of exam date - please attach a copy of lab results)

- If the patient is under 50 and has diminished renal function:

BUN _____ Creatinine _____ (Results must be within 14 days of exam date - please attach a copy of lab results)

- If patients has had bypass surgery – was the graft

Saphenous Vein: Yes _____ No _____

LIMA/RIMA: Yes _____ No _____

- If your patient is taking Glucophage® or other metformin class drugs – they must be discontinued for 48 hours after receiving contrast (before the medication is resumed the patient should have renal function labs).
 - Severe asthmatic patients require a calcium channel blocker (please provide a prescription)
 - Nothing by mouth for 6-hours prior to exam
 - No caffeine or smoking for 12-hours prior to exam
 - No erectile dysfunction medication for 72-hours prior to exam
 - Patients may take ALL other prescribed medications
-

Please call central scheduling at 954-370-4450 to schedule your patient

Please fax this script, required lab results and authorization to 954-577-2466, Attention: Christine