Berkeley Outpatient Center Cardiology
3100 San Pablo Ave., Suite 400
Berkeley, CA 94702

JOHN MUIR HEALTH | UCSF Health

Non-Invasive Cardiology Procedure Order Form

Thank you for choosing to refer your patient to the Berkeley Outpatient Center. To start the referral process, please complete this form and fax it to the corresponding fax number below.

- Physicians: for cardiology testing, fax this form to (415) 353-1784. For vascular testing, fax this form to (415) 353-2669. Physicians: for help referring a patient, call (800) 444-2559.
- Send brief, pertinent medical records, including test results and imaging that support the procedure, if available.
- Send a copy of the patient's insurance card (both sides) and HMO authorization if required.
- **Patients: to schedule a cardiology test, please call (415) 353-1262.**

Date: No. of pages: From:

To: **Berkeley Outpatient Center** Title:

Fax: Phone: Fax:

Patient Information

Name of patient: DOB:

Parent or caregiver:

Address: City: State: Zip:

Phone: ☐ work phone ☐ cell phone Insurance:

Consulting Request Information

Diagnosis/ICD-9/10:

Name of UCSF MD (if known): Specialty:

Reason for procedure:

Is authorization required? ☐ Yes ☐ No If yes, authorization number:

Procedure Requested

- ☐ 12-lead electrocardiogram (ECG)
- ☐ Ambulatory electrocardiography
  - ☐ 24-hour Holter
  - ☐ 48-hour Holter
  - ☐ 1- to 7-day extended Holter ("Zio")
  - ☐ 7- to 14-day extended Holter ("Zio")
  - ☐ Event monitor
    - ☐ 14 days ☐ 30 days
  - ☐ Telemetry
    - ☐ 14 days ☐ 30 days
- ☐ Echocardiography, 2D and 3D, with Doppler and strain
- ☐ Treadmill stress ECG
- ☐ Treadmill stress echocardiogram
- ☐ ABI
- ☐ Carotid Doppler
- ☐ Renal artery Doppler
- ☐ Upper extremity arterial
  - ☐ left ☐ right ☐ bilateral
- ☐ Upper extremity venous
  - ☐ left ☐ right ☐ bilateral
- ☐ Lower extremity arterial
  - ☐ left ☐ right ☐ bilateral
- ☐ Lower extremity venous
  - ☐ left ☐ right ☐ bilateral
- ☐ Graft imaging
  - ☐ left upper extremity
  - ☐ right upper extremity
- ☐ Abdominal aorta ultrasound

Referring Physician Information

Referring MD: Specialty:

Phone: Fax:

Primary care provider: Phone:

Signature: Date:

THIS FORM MUST BE COMPLETED AND FAXED PRIOR TO SCHEDULING.