THE QUEEN'S MEDICAL CENTER
WEST O'AHU

Outpatient Testing Order

Queen's Heart Contact: _____

Physician Office Contact: _____

FOR PHYSICIAN OFFICE USE ONLY

Scheduled Date: _____ Time: _____ Patient Name: _____ Ph (cell):_____(home):_____

Date of Birth: _____ SSN: _____ MRN: _____ HAR#: _____

Insurance: _____ Prior Auth needed? Y____ N ____ Interpreter needed/scheduled: _____

Cardiac Ultrasound	**CVNS**	**Vascular Procedures**	
□ Echocardiogram Bubble and/or Definity done PRN □ Echocardiogram with Bubble (IV required) □ Echocardiogram with Definity (IV required) □ Exercise Stress Echo (Prep required)	□ 24 hour Monitor □ 48 hour Monitor □ 3-5 Day ECG Monitor □ 3 Days □ 4 Days □ 5 Days □ 14 Day Monitor □ 30 Day Event Monitor □ EKG (walk-in only) □ Exercise Treadmill Stress Test (Prep required)	Venous Duplex □ Lower Extremity □ Upper Extremity □ Bilateral □ Right □ Left Arterial Duplex □ Lower Extremity □ Upper Extremity □ Bilateral □ Right □ Left Vein Mapping □ Lower Extremity □ Upper Extremity □ Bilateral □ Right □ Left	□ Carotid Duplex □ Renal Artery Duplex (Prep required: NPO) □ Mesenteric Duplex (Prep required: NPO) □ Without Challenge □ Arterial-Venous Fistula

Diagnosis: _____ ICD-10 Code: _____ Please Fax Report to: _____

Signs and Symptoms: _____ Stat Fax/Call to: _____

Ordering Provider Signature: _____ Date: _____ Time: _____ Please Mail Report to:

Print Provider Name/Stamp: _____ _____

CC: _____ _____

Special Instructions: _____ _____

_____ Scheduling Phone: 808-691-3663

Provider's Office Number: _____ Provider's Office Fax Number: _____ Scheduling Fax: 808-691-3678