THE QUEEN'S MEDICAL CENTER
1301 Punchbowl Street ● Honolulu, Hawaii 96813 ● Phone (808) 691-7171 ● Fax (808) 691-7007

# Coronary CTA Referral Form

**Scheduling Information** **Do you authorize the use of FFR-CT as medically indicated? Yes __ No**

Patient Name (LAST, FIRST): _____ Medical record #: _____

Date of Birth: ____/____/____ Day Phone #: _____ Cell Phone #: _____

Primary Insurance: _____ Secondary Insurance: _____

Interpreter Requested: □ YES □ NO Language: _____ PSC: _____

## PHYSICIAN REQUEST for CORONARY CTA SERVICES

**EXAM DATE:**_____ **Time:**_____ **(check in 1 hour prior for registration and prep)**

□ Coronary CTA With Calcium Score (CCTA49) □ Coronary CTA W/Out Calcium Score (CCTA48)

**Special Clinical Considerations or Questions:** _____

**Clinical Indication(s) for Scan. Please select from the following indication(s):**

□ ICD-10 code: R94.39 – Equivocal or Non-diagnostic stress test
□ ICD-10 code: I25.10 – Assessment of coronary arterial or venous anatomy to vascular procedure
□ ICD-10 code: R07.9 – Chest pain (unspecified) with intermediate-to-high Pre-test probability for CAD
□ ICD-10 codes: R07.9, R06.2, I25.810, I25.10 – As indicated for the following:
– Evaluate cause of chest pain in a patient with prior bypass surgery or stent placement
□ ICD-10 codes: R07.89, Q25.4, Q26.3, Q24.5 – Suspected congenital anomalies of coronary circulation
Other_____ ICD-10 Code_____

| PERTINENT PATIENT MEDICAL HISTORY | | |
|---|---|---|
| **Height:** | **Weight:** | **Consider another test if wt is ≥ 300 lbs.** |
| Recent BUN / CR / GFR (required)<br>GFR should be > 45 | BUN:_____ CR:_____<br>GFR:_____ Date:_____ | ☐ Ordered at:_____<br>**Fax results to CT Dept. at 808-691-7810** |
| Allergic to IV contrast, iodine | ☐ No | ☐ Yes → Pre-medicate |
| Dx of Diabetes taking Glucophage/Metformin | ☐ No | ☐ Yes → Stop Glucophage 48 hours prior |

| CARDIAC HISTORY | |
|---|---|
| History of Heart Disease? ☐ No | ☐ Yes → Describe |
| Date of last ECG:_____<br>Is patient in normal sinus rhythm? ☐ No ☐ Yes | Resting heart rate:_____ |
| Bypass Surgery (CABG) ☐ No | ☐ Yes → Location |
| Prior angioplasty / Stent? ☐ No | ☐ Yes → Location |
| Nuclear Medicine Heart Scans? ☐ No | ☐ Yes → Describe if abnormal |
| **Patient Prep:**<br>NPO 4 hours prior to exam, water ok<br>No Viagra, Cialis or Levitra 36 hours prior to exam<br>Beta Blockers as needed<br>EKG free of A-fib | **Recommended Oral Beta Blockers:**<br>1. RHR ≥ 70 – Metoprolol tartrate 100 mg – one hour prior to exam<br>2. RHR 60-70 – Metoprolol tartrate 50 mg – one hour prior to exam<br>3. RHR ≤ 60 No Beta Blockers |
| **CT Department Use Only** | |

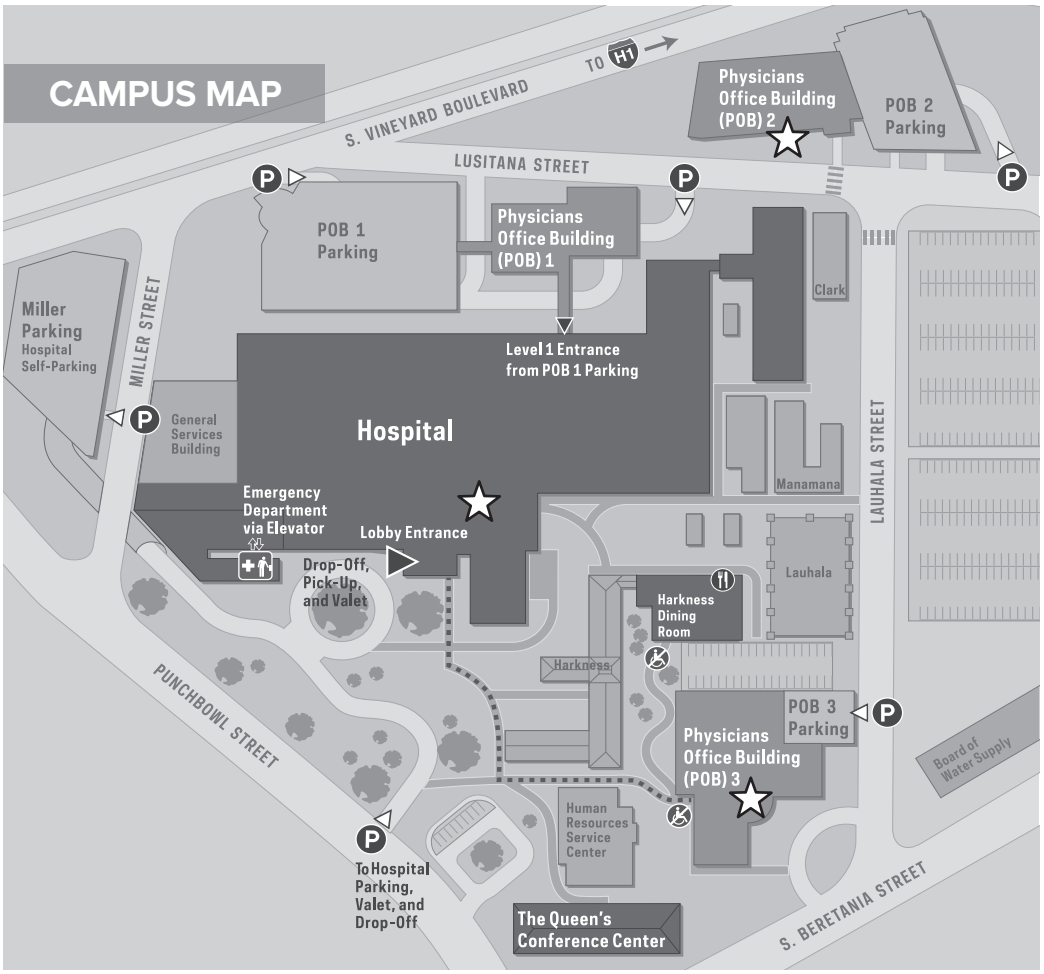
Scheduled By_____ DATE: _____ TIME: _____

_____ _____ _____
PHYSICIAN SIGNATURE PHYSICIAN NAME DATE/TIME

_____ _____
STREET ADDRESS PHONE NUMBER

8220 (01/24)

***Please sign and fax this form to 808-691-7007***




**The Queen's Medical Center – Punchbowl**

☆ **Physicians Office Building (POB) 2 – Basement Level**

☆ **Hospital – Level 1**

☆ **Physicians Office Building (POB) 3 – Basement Level**

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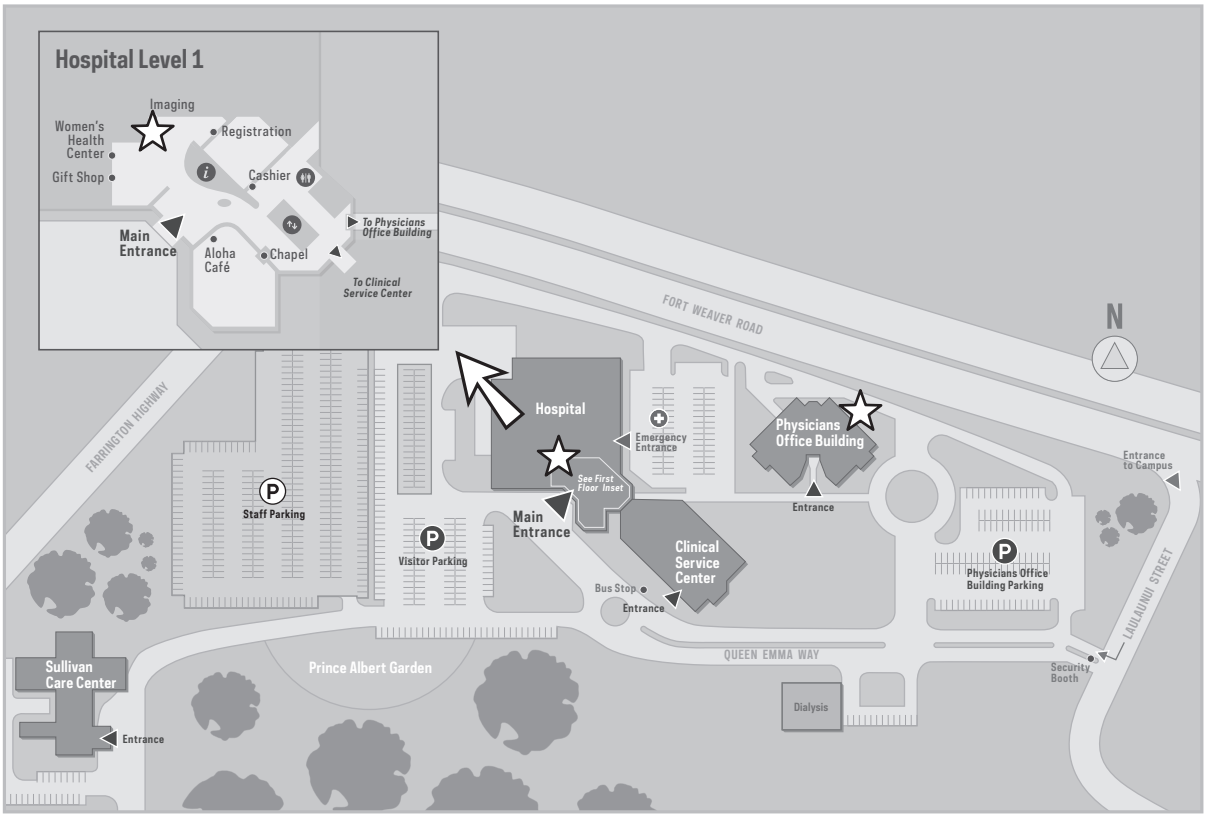


**The Queen's Medical Center – West O'ahu**

☆ **Hospital – Level 1**

☆ **Physician's Office Building (POB) West – Level 1, Suite 108**