NON-INVASIVE CARDIOLOGY REQUEST FORM

Children's Healthcare of Atlanta
The Heart Center
Cardiovascular Imaging Research Core (CIRC)
1405 Clifton Road,
N.E. Atlanta, GA 30322-
1101
Office (404)785-6476 Fax(404) 785-1277

Patient Name:_____

DOB: _____

Diagnosis:_____

MRN:_____

Account/HAR#:_____

Study Name_____Location SR_____EG_____

Parent/Guardian's Name:_____Phone:_____Cell/Work:_____
Address:_____City:_____State:____Zip: _____
Guarantor Name:_____Guarantor DOB:_____Guarantor Sex: □ M □ F
Guarantor Phone:_____Relationship to Patient:_____
Insurance/Medicaid Plan:_____Policy & Group #:_____
Please note: Outpatients that require prior authorization must have authorization on all CPT codes listed for that exam.
Authorization #:_____CPT:_____ ☑ if available & legible, please also fax copy of Insurance card

ECHOCARDIOGRAMS

__ Echo Complete (Congenital)
CPT 93303, 93320, 93325
__ Echo Complete NonCongenital)
CPT 93306
__Echo Limited (Congenital)
CPT 93304, 93321, 93325
__Echo Limited (Non-Congenital)
CPT 93308, 93321, 93325
___Fetal Complete
CPT 76825, 76827, 93325
___Fetal Limited
CPT 76826, 76827, 93325

OTHER

___Six Minute Walk Test
CPT 94620

ELECTROCARDIOGRAMS

_ Electrocardiogram
CPT 93000
_ Rhythm Strip
CPT 93041
_Rhythm monitor – Ziopatch
CPT 93225 *plus analysis fees TBD CPT 0297T

PACEMAKER ANALYSIS

___Pacemaker Single
CPT 93288
___Pacemaker Dual
CPT 93288

Vascular Exam (RESEARCH ONLY)

___cIMT ___bFMD
___PWA ___endoPAT
___PWV

Diagnostic questions: Each individual procedure code ordered must include a reason for that procedure.

_____

_____

Special requests or instructions? Sedation: Yes No Interpreter: Yes No

Other:_____

*Inform CIRC office if patient is late or rescheduled **before** appointment time so appropriate accommodations can be made*

*Allow two **(2)** business days for appointment to be scheduled and confirmed*

Ordering Physician's Signature/Date (REQUIRED):_____

Print MD Name: _____ **Coordinator Name**_____

Practice Name: _____ **Coordinator Phone** _____

Procedure Date & Time _____

Office Use Only

DATE AND TIME OF APPOINTMENT: _____ SCHEDULED BY: _____