PRE-ADMISSION TESTING NURSE INTAKE FORM
Cath Lab Scheduling: (480) 358-6548
Fax: (480) 358-6434

Patient Name (last, first)

Date of Service	Patient Phone Number	DOB	SSN

Insurance Provider - Primary (Carrier and Policy Number) | **Facility Authorization Numbers**

Insurance Provider - Secondary (Carrier and Policy Number) | **Facility Authorization Numbers**

Name of Practice	Office Phone Number	Fax Number

Ordering Physician Name	Procedure Physician (if different from ordering)	PCP

Procedure(s):
☐ Cardiac Cath: ☐ Left ☐ Right ☐ Coronary Intervention ☐ TEE ☐ Cardioversion ☐ Tilt Table
☐ Peripheral Angio ☐ Peripheral Intervention ☐ Carotid Angio ☐ Carotid Intervention
☐ Loop Recorder ☐ PPM (*circle one:* Single Dual CRT) ☐ PPM (circle one: Single Dual CRT)
☐ EP Study ☐ Ablation: (type) _____
☐ Other _____

Patient Status: ☐ Post-OP Admission (POA) ☐ Inpatient/Room _____ ☐ Outpatient ☐ 23 Hr Stay

CPT Code(s):

Patient ICD10 Dx:

Procedure Duration: _____ Anesthesia Requested: ☐ Yes ☐ No
Implant/Special Supplies: _____ Vendor Present? ☐ Yes ☐ No
Special Requests: _____ Equipment: _____

Procedure Indication: ☐ Stable Angina ☐ Unstable Angina ☐ NSTEMI ☐ STEMI ☐ Abnormal StressTest ☐ CAD ☐ Cardiomyopathy
Allergies: ☐ Dye ☐ Latex ☐ Other _____
Comorbidity Assessment: ☐ Previous MI ☐ COPD ☐ Home Oxygen ☐ Sleep Apnea ☐ CPAP ☐ CKD: Stage_____ ☐ Dialysis

Medications: Hypoglycemics: ☐ Oral ☐ Insulin ☐ None Heparin/Lovenox: ☐ Yes ☐ No Plavix: ☐ Yes ☐ No Plavix: ☐ Yes ☐ No
Other Antiplatelets: _____ Anticoagulants: _____ To be stopped _____ days prior

Orders: ☐ PreOp Testing at MVMC ☐ Use Hospital Standing Orders ☐ Preops at PCP/LabCorp/Sonora/ _____
Pre-op meds: _____
☐ LABS/XRAYS ☐ CBC ☐ CBC w Diff ☐ CMP ☐ BMP ☐ PT ☐ PTT ☐ UA ☐ UPT ☐ HCG ☐ Type & cross ☐ Type & Screen
☐ CXR ☐ EKG ☐ Other: _____ ☐ Type & Screen for units of _____

Required Patient Data to be faxed to scheduling fax at least 72 hours before day of procedure.
1. Physician Orders Faxes with Reservation. ☐ Yes ☐ No ☐ To Follow
2. History& Physical less than 30 days prior to procedure date. Attached: ☐ Yes ☐ No
3. Current medication list attached if not in H&P: ☐ Yes ☐ No ☐ If No, where?
4. Completed Informed Consent Attached: ☐ Yes ☐ No ☐ Will be done day of surgery
5. Supporting studies attached (i.e. stress test, echocardiogram, holter monitor, EKG): ☐ Yes ☐ No

Physician Signature/LIP: _____ Date: _____ Time: _____

Account Number:	MR Number:

Patient Name:
Admit Date:

* O R D E R S *

DOB	Age	Sex	HT	WT	RM-BD	PT	Svc	FC

Allergies:
Attending Physician Name:

Submit