Nebraska Heart Institute
HEART HOSPITAL

NHI CLINIC REFERRAL AND ORDER FORM

Please *complete* this order form thoroughly. Fax this order form, the demographic information, copy of the insurance cards, office notes and recent labs and tests

An appointment cannot be made without the proper forms included with this worksheet.

Patient Name _____ Date of Birth _____ /_____/_____

Patient Address _____ Social Security # _____ /____/_____

Patient Home # _____ -_____-_____ Patient Cell # _____-_____-____ Patient Work #_____-_____-_____

Patient Insurance Carrier: _____ Insurance ID number: _____ Group Number:_____

Insurance Carrier Address: _____

Signs/Symptoms (medical necessity):
(Check all that apply)

- ☐ Chest Pain
- ☐ Chest Pressure
- ☐ Fatigue
- ☐ Dyspnea on Exertion
- ☐ Weakness
- ☐ Syncope
- ☐ Hypertension
- ☐ Hyperlipidemia
- ☐ Atrial Fibrillation
- ☐ Tobacco Use
- ☐ Other_____
- ☐ Murmur
- ☐ Bruit
- ☐ Visual Disturbance
- ☐ Swelling
- ☐ Claudication
- ☐ Abdominal Pain
- ☐ Renal Insufficiency
- ☐ Leg Pain
- ☐ Palpitations
- ☐ Family Hx CAD
- ☐ Hx of_____

Requested Cardiologist:
(circle one)

S. Ackerman	D. Korpas
K. Ayala	S. Martin
P. Bajwa	O. Nass
P. Dionisopoulos	D. Netz
P. Gallagher	R. Rundlett
A. Jain	

Surgeons

D. Gangahar	S. Tyndall
G. Hedderich	J. Wudel
K. Jex	

Requested Time for Appointment:

☐ First Available ☐ Next Day ☐ 48 hrs ☐ 72 hrs ☐ 1 week ☐ Other_____

Consultation / Test Requested: **HEIGHT:** _____ **WEIGHT:** _____ **BLOOD PRESSURE:** _____ **DIABETIC: Y N**

- ☐ **Consultation Only** ☐ **Testing with Consultation**
- ☐ Echo ☐ TEE (Transesophageal Echo) ☐ EKG
- ☐ Vascular Study (specify)_____
- ☐ 24-Hour Holter Monitor
- ☐ 30-Day Event Recorder (patient does not need to come to office – device to be mailed to patient)
- ☐ Heart Catheterization
- ☐ Myocardial Perfusion Imaging
  - ☐ Treadmill (Bruce Protocol)
  - ☐ Lexiscan
  - ☐ Adenosine or Adenowalk
  - ☐ Dobutamine
- ☐ Stress Echo
  - ☐ Treadmill (Bruce Protocol)
  - ☐ Dobutamine
- ☐ Treadmill Only (Bruce Protocol)

_____ _____ /_____/_____ _____
Physician's Signature Date Form Completed by

_____ (_____) -_____-_____ (_____) -_____-_____
Physician's Name (please print) Phone FAX

Nebraska Heart Institute Medical Office Building - Lincoln, NE
7440 S. 91st Street Scheduling - Cardiology: 402-328-3998 Surgery: 402-328-3988 Fax: 402-328-3750

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FOR NHI OFFICE USE ONLY:

Appointment (date/time): _____ / _____ **Arrival Time:** _____ **with Dr.** _____

Special Instructions: ☐ None

☐ Nothing to eat or drink: after midnight / _____ ☐ Other _____

☐ NO caffeine, decaffeinated, or chocolate products 12 hours prior to the test

NHI Staff Initial

_____

Date

_____