REQUEST FOR IMAGING STUDY

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HEART SOUTH
CARDIOVASCULAR GROUP, PC

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Abilash Balmuri, M.D., FACC

Appointment Date: _____ Patient Home Phone: _____

Appointment Time: _____ Patient Cell Phone: _____

Patient Name: _____ DOB: _____ M ____ F ____

Pre Cert #: _____

Diagnosis: _____

Referring Physician (Print): _____

Referring Physician's Signature: _____ Date:_____

*****PLEASE INCLUDE PATIENT INFORMATION DEOMGRAPHIC SHEET AND COPIES OF INSURANCE CARDS*****

Renal Artery

___ Renal Artery Doppler

___ AAA / Abdominal Aorta

Echocardiogram

___ Echocardiogram (93306)

___ Echocardiogram w/contrast (93306)

NUCLEAR

___ Nuclear Stress Test (78452)

___ PET Stress Test (78492)

___ GXT (Treadmill/ No Imaging)

___ MUGA Scan (78472)

Calcium Score

___ Coronary Calcium Score (This test is not covered by insurance and cost $70.00. Payment is due at time of service)

Arterial Doppler,Venous, Carotid, ABI

___ Lower Extremity Arterial

___ Upper Extremity Arterial

___ Lower Extremity Venous

___ Upper Extremity Venous

___ Carotid Doppler

___ Segmental w/ PVR (ABI) Ankle Brachial Index