

# CARE NEW ENGLAND

## Cardiovascular Care

Patients will be scheduled into one of the five locations based on their preference.

**KENT HOSPITAL 401-736-1988**

455 Toll Gate Road, Warwick, RI 02886, fax 401-736-1010

**GARDEN CITY 401-681-4996**

65 Sockanosset Cross Road, Cranston, RI, fax 401-921-6569

**MEMORIAL HOSPITAL 401-729-2262**

111 Brewster Street, Pawtucket, RI 02860, fax 401-729-3050

**TOLL GATE ROAD 401-681-4996**

390 Toll Gate Road, Suite 205, Warwick, RI 02886  
fax 401-921-6569

**WOMEN'S CARDIOVASCULAR 401-681-4996**

90 Plain Street, Providence, RI 02905, fax 401-921-6569

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Male  Female Primary Language: \_\_\_\_\_ Interpreter Needed  Yes  No

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Primary Insurance: \_\_\_\_\_ Policy #: \_\_\_\_\_

<p><b>REFERRAL</b></p> <p><input type="checkbox"/> Consultation  <input type="checkbox"/> To a specific provider:          _____</p> <p><input type="checkbox"/> Advanced Heart Failure Clinic  <input type="checkbox"/> Cardiac Arrhythmia Clinic  <input type="checkbox"/> Advanced Valvular Heart Disease Clinic  <input type="checkbox"/> Pulmonary Hypertension Clinic  <input type="checkbox"/> Adult Congenital Heart Disease Clinic  <input type="checkbox"/> Women's Cardiovascular Health Clinic</p> <p><b>STATUS</b></p> <p><input type="checkbox"/> STAT – As soon as possible  <input type="checkbox"/> Urgent (within 48 hours)  <input type="checkbox"/> First Available  <input type="checkbox"/> Elective</p>	<p><b>STRESS TESTING</b></p> <p><input type="checkbox"/> Stress Test  <i>(Regular exercise treadmill test)</i></p> <p><input type="checkbox"/> Nuclear Stress Test  <input type="checkbox"/> Exercise*  <i>*(May be changed to pharmacologic if unable reach max predicted heart rate)</i></p> <p><input type="checkbox"/> Pharmacologic  <i>*Expectation that patient cannot exercise for 5 minutes</i></p> <p><input type="checkbox"/> Stress Echocardiogram  <input type="checkbox"/> Dobutamine  <input type="checkbox"/> with Definity contrast (IV)</p> <p><b>TESTING – NON STRESS</b></p> <p><input type="checkbox"/> Transthoracic Echocardiogram  <input type="checkbox"/> Agitated Saline          "Bubble study" (IV)  <input type="checkbox"/> With Definity contrast (IV)</p> <p><input type="checkbox"/> Electrocardiogram (ECG)  <input type="checkbox"/> Holter Monitor  <i>(May be extended prn, per Cardiologist)</i>  <input type="checkbox"/> 24 Hrs <input type="checkbox"/> 48 Hrs          Extend <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p><b>TESTING – NON STRESS (Con't)</b></p> <p><input type="checkbox"/> Cardiac Event Monitor (1 month)  <input type="checkbox"/> Transesophageal Echocardiogram*  <i>*(needs Cardiology consult)</i></p> <p><input type="checkbox"/> Non-invasive Vascular Studies  <input type="checkbox"/> Ankle Brachial Indices  <input type="checkbox"/> with Exercise Treadmill Test (ETT)  <input type="checkbox"/> Carotid Ultrasound  <input type="checkbox"/> Lower Extremity Ultrasound  <input type="checkbox"/> Graft <input type="checkbox"/> Stent  <input type="checkbox"/> Left <input type="checkbox"/> Right  <input type="checkbox"/> Upper Extremity Ultrasound  <input type="checkbox"/> Graft <input type="checkbox"/> Stent  <input type="checkbox"/> Left <input type="checkbox"/> Right  <input type="checkbox"/> Venous Insufficiency  <input type="checkbox"/> Cardiac CT  <input type="checkbox"/> Calcium Scoring  <input type="checkbox"/> Other:          _____          _____          _____</p>
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COMMENTS:

Ordering Provider: \_\_\_\_\_ Mobile Number: \_\_\_\_\_  
 Office Phone: \_\_\_\_\_ Cardiologist: \_\_\_\_\_  
 Signature: \_\_\_\_\_ Pager/Cell: \_\_\_\_\_  
 Date: \_\_\_\_\_

DIAGNOSIS								
Diagnosis			Diagnosis			Diagnosis		
794.31	Abnormal ECG		436.0	CVA		782.3	Peripheral Edema	
	Abnormal CV Exam*		250.00	Diabetes		416.0	Pulmonary Hypertension	
794.30	Abnormal Treadmill		780.4	Dizziness		443.9	Peripheral Vascular Dse	
424.1	Aortic Valve Disorder		786.09	Dyspnea		427.69	PVC	
745.5	ASD		780.79	Fatigue/Malaise		426.51	Right Bundle Branch Block	
786.51	A Typical Chest Pain		426.11	Heart Block 1st Degree		786.05	Shortness of Breath	
427.31	Atrial Fibrillation		428.0	Heart Failure		427.81	Sick Sinus Syndrome	
427.32	Atrial Flutter		785.2	Heart Murmur		785.0	Sinus Tachcardia	
427.81	Bradycardia		426.2	Hemiblock		413.9	Stable Angina	
429.3	Cardiomegaly		272.0	Hypercholesterolemia		412	Status Post MI	
425.4	Cardiomyopathy		401.1	Hypertension Controlled		427.89	SVT	
433.10	Carotid Artery Disease		401.0	Hypertension Uncontrolled		780.2	Syncope (pre)	
785.9	Carotid Bruit		458.9	Hypotension		435.9	TIA	
437.1	Cerebral Ischemic			Known Vascular Stenosis*		397.0	Disease of Tricuspid Valve	
786.59	Chest Pain		426.2	Left Bundle Branch Block			Ulcer*	
440.21	Claudication		428.1	Left Heart Failure		785.5	Unspecified Shock	
426.0	Complete Heart Block		424.0	Mitral Valve Disorder		411.1	Unstable Angina	
	Congenital Disease*		426.13	Mobitz 1			Valvular Heart Disease*	
428.0	Congestive Heart Failure		426.12	Mobitz 2		427.1	V Tach	
710.9	Connective Tissue Disease			Metabolic Syndrome*		<b>OTHER:</b>		
496.0	COPD		427.61	PAC				
414.01	Coronary Artery Dse ASHD		785.1	Palpitations				

\*Please provide additional detail in the "OTHER" section provided

### GENERAL STRESS TEST INSTRUCTIONS FOR PATIENTS:

*Talk to your doctor for more specific instructions*

- Bring insurance cards and photo ID with you to the appointment
- Bring all of your cardiac medications with you to the appointment, inhaler if you use one currently
- NO caffeine for 24 hours prior to your appointment
- Nothing to eat or drink 4 hours prior to your appointment
- Depending on appointment time, you may have a light breakfast or lunch, as long as it is not within 4 hours of test
- If you are diabetic, make sure to discuss with your Physician what medications to take prior to testing
- If you are not diabetic, take all medications with a sip of water, unless otherwise instructed

### TO REFERRING PHYSICIAN REQUESTING CONSULTATION:

*Please include a copy of:*

1. Latest office note
2. Updated medication list
3. Most recent ECG
4. Most recent labs

*Affiliated with*



**BRIGHAM AND WOMEN'S**  
Cardiovascular Associates at Care New England