

Cardiac Catheterization Form

Patient Name _____

DOB _____ Sex M F

PHN _____

Address _____ City _____

Prov _____ Postal Code _____

Patient Information or Label / Addressograph

Information marked with * is mandatory

DATE*		Physician		Telephone	
→ FAX Referral Form, History/Consult, ECG, lab results, MAR and Echo to Requested Hospital					
PATIENT LOCATION*	Hospital (Inpatient) _____ Unit _____ Unit phone # _____				Home (Outpatient)
URGENCY*	Emergent → For emergent cases please phone the on-call interventionalist at the requested hospital Urgent In-Hospital (24 to 48 hrs; max 5 days) Hospital (within 2 wks) Urgent Out of Hospital (within 6 wks)				
ALLERGIES	No Known	Local Anesthetic	Contrast	ASA	Other _____
PROCEDURE REQUESTED*	Diagnostic Cath Cath +/- PCI PCI (planned PCI)	Right Heart Cath TAVI workup Pulmonary Resistance	Aortogram Myocardial Biopsy Other _____	1 st Available Physician Specific Physician _____	
INDICATION*	STEMI → If Fibrinolysis: Date _____ Time _____ NSTEMI → Ischemic ECG changes (ST or T) → Positive troponin/marker Result Unstable Angina → Current Symptoms: Ongoing Re-MI Recurrent Pain CHF Stable Angina Arrhythmia Heart Failure Cardiomyopathy Valvular Heart Disease → Aortic _____ → Mitral _____ → Other _____ Congenital Transplant o Pre o Post Research Other _____				
CURRENT MEDICATIONS	IV Inotropes IV Nitroglycerin IV Hb/IIIa IV Heparin	LMWH Insulin Metformin in	ASA Clopidogrel Ticagrelor Dabigatran	Prasugrel Other _____	Warfarin → Will hold prior to procedure → Will require bridging therapy → Perform on Anticoagulation
CO-MORBIDITIES	Hypertension Dyslipidemia Diabetes o Type I o Type II Smoking o Current o Former COPD Prior MI Prior PCI Prior OHS o CABG o Valve				Cerebrovascular Event o Prior Stroke o Prior TIA Renal Insufficiency o Acute o Chronic Dialysis o HD o PD Peripheral Vascular Disease History of Heart Failure Suspected LV Thrombus GI Bleed within 1 year Other _____
CCS ANGINA CLASS*	Within 2 weeks I II III IV IVa IVb IVc				
NYHA CLASS*	Within 2 weeks I II III IV n/a				
PRIOR NON-INVASIVE TESTS	Exercise Stress Test Date _____ Result: Positive Negative Indeterminate MIBI Other _____ Date _____ Result: Positive				LVEF _____ % Source _____

Cardiac Catheterization Lab Billing Form

Joacim Rocklöv

A red circular graphic with a gradient, appearing as a partial circle or a stylized 'C' shape, located to the right of the name bar.

Cardiac Catheterization Lab Billing Form:

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