Lexington Heart Specialists, PSC

Diagnostic Testing & Consult Request

Please fax patient demographics & insurance cards to: (859) 899-0014

For diagnostic testing, insurance carriers require referring provider to obtain precertification.

Appointment WILL NOT be made until authorization has been obtained.

PATIENT NAME: _____ **DOB:** _____

PATIENT PHONE NUMBER(S): _____

Authorization #:_____ Rep Name: _____ Reference #:_____

_____ **Office Consultation**

***Only check this option if the patient needs a consult along with testing*

NUCLEAR IMAGING

Patient's Weight:_____

_____ **GXT (Exercise) Cardiolite Stress Test**
CPT: 78452, 93015, A9502

_____ **Lexiscan (Non-Walking) Cardiolite Stress Test**
CPT: 78452, A9502, J2765

ECHOCARDIOGRAM & CARDIOVASCULAR STUDIES

_____ **2D Echocardiogram**
CPT: 93306

_____ **GXT (Exercise) Stress Echocardiogram**
CPT: 93351

_____ **GXT Treadmill Only (No Imaging)**
CPT: 93015

_____ **Venous Duplex (Unilateral or Bilateral)**
CPT: 93971 or 93970

_____ **Arterial Duplex (Unilateral or Bilateral)**
CPT: 93926 or 93925

_____ **Carotid Duplex**
CPT: 93880

_____ **24 Hour Holter Monitor** _____ **48 Hour Holter Monitor** _____ **21 Day Event Recorder**

CARDIAC HISTORY: ____ CHF ____ CAD ____ CVA ____ Diabetes
____ CABG ____ Tobacco ____ Old MI ____ Family Hx of CAD

CURRENT SYMPTOMS: ____ Chest Pain ____ Dyspnea ____ SOB ____ Syncope ____ A-Fib ____Palps
____ Edema ____ DVT ____ Leg Pain ____ Fatigue ____ Murmur ____ Abn EKG
____ Hyperlipidemia ____ Hypertension ____ Claudication

____ Other _____

Date of Request: _____ Referring Fax #: _____

Referring MD Signature: _____ Referring Phone: _____

Referring MD Printed Name: _____ Office Contact: _____

COMMENTS: _____

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