CARDIAC CATH LAB REFERRAL NOTE

Mount Sinai Heart
One Gustave Levy Place
New York, NY, 10029
Appointment Office Tel. # (212) 241-5136
Office Tel. # (212) 241-5407
Appointment Office Fax # (212) 876-1528
Office Fax # (212) 241-4666

Patient Name: ________________________________ **DOB:** ______________

Gender: F or M (circle one) MRN: ________________ **Does patient require transportation: Yes / No**

Patient Tel #: (home) ____________ **(cell)** ______________ **(work)** ______________

Address: ____

Insurance: Primary: ____________________ **Policy #:** ________________________

Secondary: ____________________ **Policy #:** ________________________

Procedure date: ______________________ **Procedure: Cath Poss. / ICS (Circle One)**

Diagnosis: ______________ **Allergies:** ______________ **R & L Heart Cath/ Valvuloplasty**

Referring Physician: ____________________ **Tel#:** ______________ **Fax#** ____________

Referring MD Signature: ____

Accepting Physician: ____________________ **Telephone #:** ________________________

Cath lab provider who booked procedure: ________________________________

* PRE-PROCEDURE RISK ASSESSMENT (please document) *

1. Serum Creatinine ____mg/dl
2. Ejection Fraction_____ % ◯ unknown
3. Known Hx peripheral artery disease? Yes ◯ No ◯
4. Multi-vessel CAD? Yes ◯ No ◯ Unknown ◯

REASON FOR CATH

- ◯ Stable Angina
- ◯ Valve Disease
  - ◯ Mitral
  - ◯ Aortic
- ◯ Unstable Angina/ NSTEMI
- ◯ Pre Transplant Evaluation:
  - ◯ Type: ______________
- ◯ Aortic Aneurysm
- ◯ CHF
- ◯ Other ____________________

CAD RISK FACTORS

- ◯ Prior MI
- ◯ HTN
- ◯ ↑ Lipids
- ◯ +F/H
- ◯ DM
- ◯ Smoking
- ◯ Prior CABG
- ◯ CRI
- ◯ Anemia
- ◯ Obesity (Wt ________)
- ◯ Prior PCI

NON-INVASIVE TESTING Date of Study / Findings:

- ◯ ECG ______________________________
- ◯ Echo ______________________________
- ◯ CTA ______________________________
- ◯ Prior Cath ______________________________
- ◯ Stress Test ______________________________
- ◯ PET Scan ______________________________
- ◯ Nuclear ______________________________

MEDICATIONS

- ◯ Coumadin
- ◯ Other Anti-coag
- ◯ Diuretic
- ◯ Anti-hypertensive
- ◯ Insulin
- ◯ Oral Hypoglycemic
- ◯ Other ____________________
- ◯ Other ____________________
- ◯ Other ____________________
- ◯ Other ____________________
- ◯ Other ____________________

◯ Clinical Notes ____

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