

CARDIAC CATH LAB SCHEDULING FORM

OFFICE #: (818) 902-5737 or FAX #: (818) 902-5139

Date of Procedure: _____ Requested Time: _____ Length: _____

Last Name: _____ First Name: _____

Date of Birth: _____ Gender: Male Female Social Security #: _____

Primary Language: English Spanish Other: _____

Allergies: _____ HT _____ WT _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone Number (Primary): _____ Alternate Phone: _____

Parent/Guardian/Facility Name: _____

Surgeon: _____ Request Assistant: Yes No: _____

Diagnosis: _____

ICD-10: _____ CPT Code: _____

Procedure: _____

Anesthesia Type: MAC Moderate Sedation Other: _____

Co-morbidities: (Select all that apply) None Cardiac/Vascular Disease/Hypertension

Endocrine/Diabetes/Thyroid Disease Respiratory Disease (Smoker/Sleep Apnea) Kidney Disease

Liver Disease Neurologic Disease Hematologic/Bleeding Disorders

Insurance Name: _____ Policy Number: _____

Insurance Type: HMO PPO MediCare MediCal

If HMO IPA Name: _____ Days Approved: _____

Authorization Number: _____ N/A Exp. Date: _____

Special Equipment (Implants/Hardware): NONE _____

Vendor/Rep None _____ Tel: _____ E-mail: _____

****PLEASE ATTACH A COPY OF AUTHORIZATION, IDENTIFICATION CARD, COPY OF INSURANCE CARD(S) (Front & Back) H&P (within 30 days), ORDERS and LABS (within 30 days).**



VALLEY PRESBYTERIAN
HOSPITAL