

CARDIAC CATH LAB SCHEDULING FORM

Fax# 818.902.5139 or [email:CCLscheduling@valleypres.org](mailto:CCLscheduling@valleypres.org)

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 _____

Comorbidities: (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 _____

PLEASE ATTACH A COPY OF AUTHORIZATION, IDENTIFICATION CARD, COPY OF INSURANCE CARD(S) (Front & Back)

Special Equipment (Implants/Hardware): NONE _____

Vendor /Rep None _____

Tel: _____ Email _____