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Central Coast
Comprehensive
Cardiovascular
IMAGING

Non-Invasive Cardiovascular Testing Request

Patient Name: _____ DOB: _____

Diagnosis: _____ Phone: _____

Insurance/Authorization: _____

Please include a copy of the insurance card (FRONT and BACK)

Height: _____ Weight: _____ Allergies: _____

Test is: ___ Routine ___ Urgent

Non-invasive Office Based Testing

- ___ Echocardiogram
- ___ Exercise Stress Echocardiogram
- ___ Dobutamine Pharmacologic Stress Echocardiogram
- ___ Exercise Stress Nuclear Myocardial Perfusion Imaging (MPI)
- ___ Adenosine/Lexiscan Pharmacologic Stress Nuclear MPI
- ___ Carotid Ultrasound
- ___ Arterial Ultrasound of Lower Extremities - Specify (R / L / bilateral)
- ___ Venous Ultrasound - Specify (R / L / Bilateral) & Extremity (Upper / Lower)
- ___ Holter Monitor (24 hours)
- ___ Event Monitor

Ordering Physician: _____ (signature required)