

OUTPATIENT REQUEST FORM NUCLEAR MEDICINE

APPOINTMENTS: (808) 485-4607 | FAX: (808) 485-3852

HAWAII
PACIFIC
HEALTH

PALI MOMI
MEDICAL CENTER 

APPOINTMENT DATE: _____ TIME: _____

Call Patient to Schedule Appointment

Please check in at the Registration Department 30 minutes prior to appointment if you have not pre-registered.

Record Decision Support Information

Decision Support Vendor: _____

Decision Support Adherence: _____

Decision Support Session ID: _____

Decision Support Score: _____

(Please complete when ordering Nuclear Medicine)

PATIENT INFORMATION

Last Name _____ First Name _____ Date of Birth _____

Primary Phone Number _____ Height _____ Weight _____ Primary Insurance _____

Not Required In Progress Completed

Authorization #: _____ Auth # Effective Dates _____

Pregnant: Yes No Breastfeeding: Yes No Asthma: Yes No Allergies: Yes No

Allergies: _____

MYOCARDIAL EXAMS

- Treadmill Only (NO SCAN)
- NM Myocardial Perfusion Scan (Select one of the following):
 - Treadmill
 - Regadenoson (Lexiscan)
 - Dobutamine

Myocardial Exams Prep:

- No Caffeine 24 hours prior to test
- Nothing by mouth after midnight
- If diabetic, please eat a small breakfast (toast, juice)

DIAGNOSIS FOR MYOCARDIAL EXAMS:

- | | | |
|---|--|--|
| <input type="checkbox"/> R07.2 Precordial Chest Pain | Coronary Atherosclerosis (ASHD) | <input type="checkbox"/> I49.5 Sick Sinus Syndrome |
| <input type="checkbox"/> R07.89 Chest Pain, unspecified | <input type="checkbox"/> I25.10 Native Artery without Angina | <input type="checkbox"/> I50.1 Left Heart Failure |
| <input type="checkbox"/> I11.0 Hypertensive heart disease without heart failure | <input type="checkbox"/> I25.810 Bypass Grafts without Angina | <input type="checkbox"/> I51.7 Cardiomegaly |
| <input type="checkbox"/> I11.9 Hypertensive heart disease without heart failure | <input type="checkbox"/> I25.89 Chronic Ischemic Heart Disease | <input type="checkbox"/> R55 Syncope |
| <input type="checkbox"/> I21.01 MI Involving left main | <input type="checkbox"/> I25.5 Ischemic Cardiomyopathy | <input type="checkbox"/> R00.2 Palpitations |
| <input type="checkbox"/> I21.4 NSTEMI | <input type="checkbox"/> I42.0 Dilated Cardiomyopathy | <input type="checkbox"/> R06.02 Shortness of Breath |
| <input type="checkbox"/> I25.2 Old MI | <input type="checkbox"/> I48.0 Paroxysmal Atrial Fibrillation | <input type="checkbox"/> R94.31 Abnormal ECG |
| Other: _____ | <input type="checkbox"/> I48.1 Persistent Atrial Fibrillation | <input type="checkbox"/> Z01.810 Preoperative Evaluation |
| | <input type="checkbox"/> I48.2 Chronic Atrial Fibrillation | |
| | <input type="checkbox"/> I49.01 Ventricular Fibrillation | |

NON-MYOCARDIAL EXAMS

- | | | |
|---|---|---|
| <input type="checkbox"/> NM Bone Scan: 3 Phase | <input type="checkbox"/> NM Lung VQ | <input type="checkbox"/> NM Thyroid CA METS: Whole Body |
| <input type="checkbox"/> NM Bone Scan: Multiple | <input type="checkbox"/> NM MUGA Scan | <input type="checkbox"/> NM Thyroid Imaging: Only |
| <input type="checkbox"/> NM Bone Scan: Whole Body | <input type="checkbox"/> NM Parathyroid Imaging | <input type="checkbox"/> NM Thyroid Update & Scan |
| <input type="checkbox"/> NM Breast Sentinel | <input type="checkbox"/> NM Renal with Captopril | <input type="checkbox"/> TSH _____ Free T4 _____ |
| <input type="checkbox"/> NM Gastric Emptying | <input type="checkbox"/> NM Renal with Lasix BUN _____ Creatinine _____ | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> NM HIDA Scan | <input type="checkbox"/> NM Renal: Non Pharmacologic | |
| <input type="checkbox"/> NM HIDA Scan with CCK | <input type="checkbox"/> NM RX Thyroid CA Ablation | |

DIAGNOSIS: _____

PHYSICIAN INFORMATION

Ordering Physician Signature _____ Date _____

Ordering Physician Name _____ Phone Number _____

CC Physician(s) _____