CARDIOVASCULAR INSTITUTE
OF NORTHWEST FLORIDA

625 W. Baldwin Road, Suite C
Panama City, FL 32405
Phone: 850-769-0329
Referral Fax: 888-204-4626

B. Anthony Evans, M.D., F.A.C.C.
Amir R. Haghighat, M.D., F.A.C.C.
Nghia Hoang, D.O., F.H.R.S., C.C.D.S.

Saeed Khaja, D.O., M.B.A., F.A.C.C.
Timothy D. McShurley, M.D., F.A.C.C.
Ajay U. Mhatre, M.D., F.A.C.C., F.S.C.A.I.
Michael F. Morrow, M.D., F.A.C.C.

Samir N. Patel, M. D., F.A.C.C., F.S.C.A.I.
Michael J. Stokes, M.D., F.A.C.C.
J. L. Trantham, M.D., F.A.C.C.

ORDERING PHYSICIAN'S STUDY REQUEST

---------Please fax to (888)204-4626 so that we may pre-certify and call patient to schedule.----------

DIAGNOSIS		
	APPOINTMENT TYPE: (check one)	☐ Next Available ☐ ASAP (within 3-5 business days) ☐STAT (same or next business day) *NOTE: For faster processing of STAT appointments, a follow-up phone call is recommended.*
	DIAGNOSIS / SYMPTOMS:	

PATIENT INFORMATION								
	DATE	/ /	PATIENT NAME					
	HOME PHONE #			CELL PHONE #				
	STREET ADDRESS							
	CITY		STATE		ZIP			
	DATE OF BIRTH	/ /	AGE		SOCIAL SECURITY #			
	SEX	MALE _____ FEMALE _____	Please fax a copy (front & back) of the patient's insurance card					
	INSURANCE COMPANY							
	INSURANCE ID#							

FROM				
	ORDERING PROVIDER NAME (Print)		PHONE #	
	PROVIDER SIGNATURE		FAX #	

Place a ✓in the box next to the study(ies) requested to be completed.

	PHYSICIAN CONSULTATIONS
	New patient cardiology evaluation
	Established patient cardiology evaluation
	Vascular and/or varicose vein evaluation
	Carotid vascular consult
	NUCLEAR MEDICINE IMAGING
	Nuclear Exercise Stress Test
	Pharmacologic Nuclear Stress Test (non-exercise)
	MUGA
	Viability Study
	Cardiac PET / CT Myocardial Perfusion Scan **
	OTHER DIAGNOSTIC TESTING
	Graded Exercise Tolerance Test (Treadmill)
	Holter Monitor (24 hour)
	Event Monitor (4 week - a Holter must be ordered prior)
	EKG Only

	ULTRASOUND IMAGING
	Echo w/Doppler
	Carotid Sonogram
	Abdominal Aortic Sonogram*
	Renal Artery Sonogram*
	Mesenteric Doppler Sonogram*
	Duplex Arterial Sonogram Lower Extremity ____Bil. ____Rt. ____Lt.
	Duplex Arterial Sonogram Upper Ext. (Subclavian) __Bil. __Rt. ___Lt.
	Duplex Venous Sonogram Lower Ext. (For DVT) ___Bil. ___Rt. ___Lt.
	Bil. Duplex Venous Sonogram Lower Ext. (for Insufficiency / Reflux)
	Duplex Venous Sonogram Upper Ext. _____Rt. _____Lt.
	Rest & Exercise Ankle Brachial Index (ABI)
	** NPO 4 hrs, no caffeine 12 hrs
	*Patient must be fasting for a minimum of 8 hours prior. (Can drink small amount of water with their medications.)