

CORONARY CT ANGIOGRAPHY SCAN

NAME _____

CLINIC # _____

DATE OF EXAM _____ AGE _____

REFERRING PHYSICIAN _____

Primary Diagnosis/Symptoms/Indications: _____

Dx Code: _____

Dx Code: _____

Dx Code: _____

HEART CTA ORDER:

CCTA: without smart score _____ with smart score _____ Ejection Fraction _____ Wall Motion _____

Chest CT: Full _____ Pulmonary Veins _____ Pre EP Study _____

Bypass Localization _____ Mammary Artery Localization _____

Other _____

What information do you wish to obtain from the scan? _____

Is Patient:

Diabetic: On Glucophage _____ OR Metformin _____ Weight _____

Allergy to IV Contrast: _____ No _____ Yes

On Erectile Dysfunction Drugs or Alpha-Blockers? _____ No _____ Yes Drug: _____

History of Heart Disease: _____ No _____ Yes If Yes, describe: _____

Creatinine done in last 30 days _____ No _____ Yes Creatinine level _____

EKG done in last 30 days _____ No _____ Yes Is patient in normal sinus rhythm? _____ No _____ Yes

Previous Studies:

Nuclear Medicine Heart Scans: _____ No _____ Yes If abnormal, describe _____

Cardiac Catheterization: _____ No _____ Yes Cardiac Surgeries: _____ No _____ Yes

Pacemaker/ICD _____ No _____ Yes Stent Placement: _____ No _____ Yes

Location of stents: _____

Bypass Surgery: _____ No _____ Yes Location of bypass: _____

Ordered by:

Signature: _____ Date: _____

Verified by:

Signature: _____ Date: _____

CT Use



MERITCARE HEALTH SYSTEM
CCTA Patient Information



Patient Name: _____ *Date:* _____
Referring Physician: _____ *Physician Phone #:* _____

1. Do you have a history of heart disease? *Yes* ____ *No* ____
 If *Yes* , please explain _____
2. Do you have high blood pressure? *Yes* ____ *No* ____
3. Do you have high cholesterol? *Yes* ____ *No* ____
4. Do you have diabetes mellitus? *Yes* ____ *No* ____
 If *Yes* , do you take metfomin or glucophage? *Yes* ____ *No* ____
5. Do you or have you used tobacco? *Yes* ____ *No* ____
 If *Yes* , how much and for how long? _____
6. Is there a family history of heart disease? *Yes* ____ *No* ____
7. Do you have a history of kidney disease? *Yes* ____ *No* ____
8. Are you allergic to iodine or x-ray contrast *Yes* ____ *No* ____
9. Do you have asthma? *Yes* ____ *No* ____
10. Do you have a pacemaker? *Yes* ____ *No* ____
11. Do you use any medications for erectile dysfunction such as Viagra, Cialis, Levitra
 or any alpha blocking agents for your prostrate such as Hytrin? *Yes* ____ *No* ____
12. Do you have symptoms of chest pain, shortness of breath or dizziness? *Yes* ____ *No* ____
 If *Yes* , please explain _____
13. Do you have a heart murmur? *Yes* ____ *No* ____
14. Are you allergic to medication? *Yes* ____ *No* ____
 If *Yes* , what are those medications? _____
15. Who is your primary care physician? _____