Lexington Heart Specialists, PSC

Diagnostic Testing & Consult Request

Please fax patient demographics & insurance cards to: (859) 899-0014
For diagnostic testing, insurance carriers require referring provider to obtain precertification.
Appointment WILL NOT be made until authorization has been obtained.

PATIENT NAME: ____ **DOB:** ____________________

PATIENT PHONE NUMBER(S): ____

Authorization #:____________________ Rep Name: ___________________ Reference #:_______________

_____ **Office Consultation**
**Only check this option if the patient needs a consult along with testing*

NUCLEAR IMAGING

Patient's Weight:_________

_____ **GXT (Exercise) Cardiolite Stress Test**
CPT: 78452, 93015, A9502

_____ **Lexiscan (Non-Walking) Cardiolite Stress Test**
CPT: 78452, A9502, J2765

ECHOCARDIOGRAM & CARDIOVASCULAR STUDIES

_____ **2D Echocardiogram**
CPT: 93306

_____ **GXT (Exercise) Stress Echocardiogram**
CPT: 93351

_____ **GXT Treadmill Only (No Imaging)**
CPT: 93015

_____ **Venous Duplex (Unilateral or Bilateral)**
CPT: 93971 or 93970

_____ **Arterial Duplex (Unilateral or Bilateral)**
CPT: 93926 or 93925

_____ **Carotid Duplex**
CPT: 93880

_____ **24 Hour Holter Monitor** _____ **48 Hour Holter Monitor** _____ **21 Day Event Recorder**

CARDIAC HISTORY: ____ CHF ____ CAD ____ CVA ____ Diabetes
____ CABG ____ Tobacco ____ Old MI ____ Family Hx of CAD

CURRENT SYMPTOMS: ____ Chest Pain ____ Dyspnea ____ SOB ____ Syncope ____ A-Fib ____Palps
____ Edema ____ DVT ____ Leg Pain ____ Fatigue ____ Murmur ____ Abn EKG
____ Hyperlipidemia ____ Hypertension ____ Claudication

____ Other ____

Date of Request: ____________________________________

Referring Fax #: ____________________________

Referring MD Signature: _______________________________

Referring Phone: ___________________________

Referring MD Printed Name: ____________________________

Office Contact: ____________________________

COMMENTS: ____
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