

Order Form (Patient MUST bring this form on the date of service)

Date: _____ Time: _____ a.m. p.m.

Patient Name: _____ Date of Birth: _____

Referring Physician (print): _____

Referring Physician (signature): _____

Office Contact Number: _____

Symptoms / Diagnosis: _____

A note to all ordering clinicians: Test should only be ordered that are medically necessary for the diagnosis, symptoms and or treatment. The patient may be billed for tests that are not deemed necessary by payers. Please submit ALL (appropriate) clinical indications for ALL test(s) ordered. Ordering Physician offices MUST obtain pre certification of exams if required.

- | | |
|---|---|
| <input type="checkbox"/> Doppler – Carotid | <input type="checkbox"/> Echocardiogram – Transesophageal |
| <input type="checkbox"/> Doppler Arterial – Lower Extremity | <input type="checkbox"/> Echocardiogram – Transesophageal with Contrast |
| <input type="checkbox"/> Doppler Arterial – Upper Extremity | <input type="checkbox"/> Electrocardiogram (EKG) 12 lead |
| <input type="checkbox"/> Holter Monitor – 24 Hour | <input type="checkbox"/> Stress Test – Exercise Treadmill |
| <input type="checkbox"/> Holter Monitor – 48 Hour | <input type="checkbox"/> Stress Test – Lexiscan |
| <input type="checkbox"/> Echocardiogram | <input type="checkbox"/> Stress Test – Dobutamine |
| <input type="checkbox"/> Echocardiogram with Contrast | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Echocardiogram – Stress | |

If you have any questions, please contact the Cardiology Department at 714-524-4863. Thank you for choosing Placentia-Linda Hospital.



Placentia-Linda

HOSPITALSM

We feature inpatient and outpatient Cardiology and are committed to the well-being of your patients. For appointments, please call **714-961-5915**.

We accept:

- ✓ **Most Health Plans/Covered California Plans**
- ✓ **Medicare**
- ✓ **Worker's Compensation**
- ✓ **Cash Pay**

Please bring your insurance/Medicare card with you.

We look forward to seeing you!

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