To schedule or cancel, please call Interventional Radiology 1-231-487-7326
and Fax completed form to 1-231-487-7473

Patient Name:	**Date of Birth:**

Scan type:

☐ **CCTA WITH CALCIUM SCORE** (Standard)

☐ **CCTA WITHOUT CALCIUM SCORE**

PRACTITIONER TO COMPLETE BOTH SECTIONS A AND B

SECTION A – INDICATION(S) FOR CCTA SCAN – at least one must be checked

1. ☐ SYMPTOMS SUGGESTIVE OF CORONARY ARTERY DISEASE (CAD) (See Section B)

2. PRIOR STRESS TEST* WITHIN 6 MONTHS (choose one)
- ☐ Equivocal stress test
- ☐ Normal stress test and continued symptoms
- ☐ Discordant ECG & imaging
- ☐ Low-to-intermediate pretest likelihood and unable to exercise or uninterpretable ECG

***Result of stress test**

Nuclear:
☐Normal ☐ Equivocal ☐Mild Abn ☐Mod Abn ☐Sev Abn

ECHO:
☐Normal ☐ Equivocal ☐Mild Abn ☐Mod Abn ☐Sev Abn

EKG Stress:
☐Normal ☐ Equivocal ☐Mild Abn ☐Mod Abn ☐Sev Abn

3. KNOWN CAD
- ☐ Bypass graft w/ ischemic symptoms
- ☐ Prior coronary stents
- ☐ Coronary bypass grafts & retrosternal anatomy prior to planned re-do CABG surgery
- ☐ Other, specify_____

4. ☐ NEW ONSET OR NEWLY DIAGNOSED HEART FAILURE AND LOW-T0-INTERMEDIATE PROBABILITY OF CORONARY DISEASE

5. ☐ SUSPECTED CORONARY ANOMALIES

6. FOLLOWING STRUCTURES NOT ADEQUATELY EVALUATED ON 2D ECHO, TEE OR CARDIAC MRI
- ☐ Cardiac mass
- ☐ Aortic valve morphology
- ☐ Mitral valve morphology
- ☐ Ventricular function or LV morphology
- ☐ Congenital heart disease: specify: _____
- ☐ Pericardial disease

7. INTERMEDIATE LIKELIHOOD OF CAD AND PREOPERATIVE EVALUATION

8. CORONARY RISK FACTORS PRESENT

9. ☐ RESEARCH

10. OTHER INDICATION, specify_____

SECTION B – SYMPTOMS

Symptom Type - **check all that apply**	*Quality of Symptom* - **check all that apply**	*Duration of Symptom* - **check one**
☐ Chest pain or pressure	☐ Substernal	☐ Acute (less than 24 hours)
☐ Dyspnea	☐ Occurs with activity	ECG: ☐Negative ☐Nondiagnostic
☐ Arm pain	☐ Relieved with SL NTG and/or rest	Enzymes: ☐Negative ☐Nondiagnostic
☐ Jaw pain		☐ New Onset (less than 1 month)
☐ Back pain		☐ Chronic
☐ Other symptom _____		☐ Unknown

Pre-scan Evaluation:

CREATININE / GFR Date:_____ Creatinine: _____ mg/dL **- or-** GFR: _____ (performed in Interventional Radiology if no results within 30 days of test)

Referring Practitioner (print full name):	**Office Phone No.**	**Office Fax No.**
Practitioner Signature:		**Date:**

Preauthorization Number: _____ NOTE: For insurance purposes, screening for coronary disease in asymptomatic individuals is considered an inappropriate indication, and may not be covered.

Patient Scheduling Preference Dates: _____ **Times:** _____

Scheduled Date: _____ **Time:** _____

McLaren
NORTHERN MICHIGAN

Cardiac Computed Tomography Angiography (CCTA) Order

MNM 999.448

(11/28/2016)