

Cardiac Imaging Referral Form

To Schedule: 415-925-7301 To Fax Orders: 415-464-5459

Please attach clinical note and patient demographics/insurance

***Required Fields**

*Patient Name: _____ *Date of birth: _____

*Patient Phone: _____ Authorization Number: _____

*Ordering Provider Name: _____ *Ordering Provider Phone #: _____

***Ordering Provider Signature:** _____ Date/Time: _____

CC Report(s) To: _____

Clinical History (Check all that apply)

- Pacemaker ICD External Defibrillator Loop Recorder Renal Insufficiency

Exam Requested: (Check all that apply)

Nuclear Testing <input type="checkbox"/> PET-CT 78431, 78431 <input type="checkbox"/> Myocardial Perfusion Treadmill Stress 78452 <input type="checkbox"/> Myocardial Perfusion Pharmacologic Stress Test 78452 <input type="checkbox"/> Pyrophosphate for Amyloidosis (PYP) 78803 *if available	Cardiac CT <input type="checkbox"/> Coronary Calcium Score 75571 <input type="checkbox"/> Coronary CT Angiogram 75574 FFRCT and/or plaque analysis may be added at the discretion of the reader based on current imaging guidelines (FFRCT for visible stenoses 40%-90% and plaque analysis for stenoses 1%-70%). <input type="checkbox"/> Screening Coronary CTA: Reflex plaque analysis - CASH PAY <input type="checkbox"/> CTA TAVR Chest/Abd/Pelvis 71275, 74174, 75574 Iodine Contrast Allergy: <input type="checkbox"/> Yes <input type="checkbox"/> No *Need BMP within 6 weeks of study Must include Page 2 (Medication order)	<input type="checkbox"/> Cardiac MRI with Flow Mapping W/WO contrast 75561, 75565 Indications/Protocols: <input type="checkbox"/> Cardiomyopathy/viability <input type="checkbox"/> Hypertrophic cardiomyopathy <input type="checkbox"/> Pericarditis/myocarditis <input type="checkbox"/> ARVD <input type="checkbox"/> ASD <input type="checkbox"/> VSD <input type="checkbox"/> Hemochromatosis <input type="checkbox"/> Infiltrative cardiomyopathy/cardiac amyloidosis MRI Contrast Allergy: <input type="checkbox"/> Yes <input type="checkbox"/> No * *Need BMP and HCT within 4 weeks of study
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Reasons for Test: (Check all that apply)

- | | |
|---------------------------------------------------------|--------------------------------------------------------|
| <input type="checkbox"/> Chest Pain R07.9 | <input type="checkbox"/> Coronary Artery Disease 125.1 |
| <input type="checkbox"/> Shortness of Breath R06.00 | <input type="checkbox"/> Post MI Evaluation I25.2 |
| <input type="checkbox"/> Abnormal ECG R94.31 | <input type="checkbox"/> Post CABG Evaluation Z95.1 |
| <input type="checkbox"/> Abnormal Treadmill Test R94.39 | <input type="checkbox"/> Post PTCA Evaluation Z98.61 |

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250 Bon Air Road
Greenbrae, CA 94904
415-925-7000

**CARDIAC IMAGING
REFERRAL FORM**

dTpo

Form M7636-1400
Rev. 03/24/2026
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CTA Coronary Medication Order Set | PHYSICIAN'S ORDER

MEDICATIONS

Optimal image quality for CT coronary angiography is achieved with heart rate less than 60 bpm. Please prescribe both oral and IV rate-control agents as appropriate.

ORAL RATE CONTROL — TO BE ORDERED BY MD

Send to patient's pharmacy prior to study

- metoprolol tartrate (Lopressor) oral tablet – take 90 minutes prior to CT scan
 - metoprolol tartrate (Lopressor) 25 mg
Disp-1 tablet, R-0
 - metoprolol tartrate (Lopressor) 50 mg
Disp-2 tablet, R-0
 - metoprolol tartrate (Lopressor) 75 mg
Disp-3 tablet, R-0
 - metoprolol tartrate (Lopressor) 100 mg
Disp-1 tablet, R-0
- diltiazem (Cardizem) oral tablet — if contraindicated to metoprolol
 - 30mg 60mg 90mg 120 mg

INTRA-PROCEDURE ORDERS:

Metoprolol or Diltiazem Orders (must choose one)

- metoprolol (Lopressor) IV
5 mg IV q5 min PRN to HR \leq 60 bpm; max 15 mg total.
Hold if SBP <90 mmHg, DBP <60 mmHg, or HR <55 bpm.
- diltiazem (Cardizem) IV — if contraindicated to metoprolol
10 mg IV q10 min PRN \times 3 to HR \leq 60 bpm; max 30 mg total.
Hold if SBP <90 mmHg, DBP <60 mmHg, or HR <55 bpm.

Nitroglycerin Orders (must choose one)

- nitroglycerin (Nitrostat) SL tablet
0.8 mg SL once PRN, pre-imaging.
Give 5 minutes prior to CT scan if SBP \geq 100 mmHg.
 - NTG contraindicated — patient has aortic stenosis.
- 0.9% sodium chloride flush syringe
10 mL IV PRN, line care / radiologic IV contrast preparation (2 doses).
Give prior to contrast injection and after contrast injection to ensure patency.

Provider Signature: _____ Date/Time: _____

Print Name: _____



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