

Cardiac Imaging Referral Form

To Schedule: 415-925-7301 To Fax Orders: 415-925-7317

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)

Chest Pain R07.9 Coronary Artery Disease 125.1
 Shortness of Breath R06.00 Post MI Evaluation I25.2
 Abnormal ECG R94.31 Post CABG Evaluation Z95.1
 Abnormal Treadmill Test R94.39 Post PTCA Evaluation Z98.61

(Continued on page 2)



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

**CARDIAC IMAGING
REFERRAL FORM**

dTpo

Form M7636-1400
Rev. 03/24/2026
Page 1 of 2

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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