ELECTRA MEMORIAL HOSPITAL

CARDIOVASCULAR ORDER FORM

PLEASE FAX TO (940) 298-1640

PATIENT INFORMATION

Patient Name : _____ DOB: _____

Phone Number: _____ Insurance: _____

Height: _____ Weight: _____ Ordering Provider: _____

Clinical History/DX: _____

CARDIAC	VASCULAR ULTRASOUND

○ EKG
○ Echocardiogram Complete
○ Echocardiogram without Doppler (Limited)
○ Cardiac Monitor
  ○ 24 Hour
  ○ 48 Hour
○ Cardiac stress test
○ Ankle/Brachial Index (ABI)
	○ Abdominal Aorta
	○ Arterial Lower Extremity Bilateral
	○ Arterial Lower Extremity Unilateral
	  ○ Right Leg
	  ○ Left Leg
	○ Arterial upper Extremity Bilateral
	○ Arterial Upper Extremity Unilateral
	  ○ Right Arm
	  ○ Left Arm
	○ Carotid
	○ Renal Artery
	○ Venous Lower Extremity Bilateral
	○ Venous Lower Extremity Unilateral
	  ○ Right Leg
	  ○ Left Leg
	○ Venous Upper Extremity Bilateral
	○ Venous Upper Extremity Unilateral
	  ○ Right Arm
	  ○ Left Arm

HEALTHCARE PROVIDER INFORMATION

Ordering physician name:_____ NPI: _____

SIGNATURE (required): _____

1207 S. Bailey St
Electra, TX 76360

www.electrahospital .com

Phone (940) 495-5171
Fax (940) 298-1640