NHI CLINIC REFERRAL AND ORDER FORM – KEARNEY

Please complete this order form thoroughly. Fax this order form, the demographic information, copy of the insurance cards (both sides), office notes, and recent labs and tests to 308-865-2045.

Patient Name ________________________________ M F DOB _____/_____/_____ SSN ______-_____-_______

Patient Address: ________________________________ Patient City/State/Zip ________________________

Patient Home # ______ -______-________ Patient Work # ______-______-________ Patient Cell # ______-______-________

Patient Insurance Carrier: ______________________ Insurance ID number: ______________ Group Number: _________

Insurance Address: ________________________________ Insurance City/State/Zip ________________________

Subscriber Name (if not patient) ________________________ M F DOB _____/_____/_____ SSN ______-_____-_______

Signs/Symptoms (medical necessity):
(Check all that apply)

- ☐ Chest Pain
- ☐ Chest Pressure
- ☐ Fatigue
- ☐ Dyspnea on Exertion
- ☐ Weakness
- ☐ Syncope
- ☐ Hypertension
- ☐ Hyperlipidemia
- ☐ Atrial Fibrillation
- ☐ Tobacco Use
- ☐ Other______________
- ☐ Murmur
- ☐ Bruit
- ☐ Visual Disturbance
- ☐ Swelling
- ☐ Claudication
- ☐ Abdominal Pain
- ☐ Renal Insufficiency
- ☐ Leg Pain
- ☐ Palpitations
- ☐ Family Hx CAD
- ☐ Hx of______________

Requested Cardiologist:
(circle one)

Dr. Alain Efstratiou

Dr. Anuradha Tunuguntla

Dr. Lakshmi Yerra

Requested Time for Appointment:

☐ First Available ☐ Next Day ☐ 48 hrs ☐ 72 hrs ☐ 1 week ☐ Other _____________

Consultation / Test Requested: **HEIGHT:** _____ **WEIGHT:** _____ **BLOOD PRESSURE:** ______ **DIABETIC: Y N**

- ☐ **Consultation Only**
- ☐ **Testing with Consultation**
- ☐ Echo
- ☐ TEE (Transesophageal Echo)
- ☐ EKG
- ☐ Vascular Study (specify)________________________________
- ☐ 24-Hour Holter Monitor
- ☐ 30-Day Event Recorder (patient does not need to come to office – device to be mailed to patient)
- ☐ Heart Catheterization
- ☐ Myocardial Perfusion Imaging
  - ☐ Treadmill (Bruce Protocol)
  - ☐ Lexiscan
  - ☐ Adenosine or Adenowalk
  - ☐ Dobutamine
- ☐ Stress Echo
  - ☐ Treadmill (Bruce Protocol)
  - ☐ Dobutamine
- ☐ Treadmill Only (Bruce Protocol)

________________________________ ______/______/_______ ________________________________
Physician's Signature Date Form Completed by

________________________________ (_____) -______-_______ (_____) -______-_______
Physician's Name (please print) Phone FAX

Nebraska Heart Institute, 3219 Central Ave., Suite 201, Kearney, NE 68847
Scheduling Center: 308-865-7271 Fax: 308-865-2045

FOR NHI OFFICE USE ONLY:

Appointment (date/time): __________ / __________ Arrival Time: __________ with Dr. ______________________

Special Instructions: ☐ None

☐ Nothing to eat or drink: after midnight / _________ ☐ Other ________________________________

☐ NO caffeine, decaffeinated, or chocolate products 12 hours prior to the test

NHI Staff Initial __________

Date __________