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|---|--|----------------------|-----|---|-----------------------|----------------------|------|
| Patient's Last Name | | Patient's First Name | | MI | Requested Date | | Time |
| Sex: <input type="checkbox"/> M <input type="checkbox"/> F | | Home Phone | | Cell Phone | | Work Phone | |
| DOB | | SSN | | Patient Weight | Research Study Name | | |
| Insurance Name | | | | Insurance ID Number | | Authorization Number | |
| Office Contact & Phone No. | | | | <input type="checkbox"/> Outpatient <input type="checkbox"/> Inpatient | | Inpatient Room # | |
| Physician's Name | | | NPI | | Physician's Signature | | Date |


TMH089

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|--|--|--|--|
| REQUIRED OUTPATIENT INFORMATION | | | |
| Patient Registered: <input type="checkbox"/> Yes <input type="checkbox"/> No | | Lab Work Complete: <input type="checkbox"/> Yes <input type="checkbox"/> No Where Drawn: | |
| Order, Labs, & H&P must be faxed to 713.791.5060 Scheduling phone number: 346.238.7453 | | | |
| Comprehensive H&P completed within 30 days: <input type="checkbox"/> Yes <input type="checkbox"/> No Greater than 30 days requires a new H&P. | | | |
| Update completed H&P within 24 hours prior to procedure: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA | | | |
| * First, second and third cases require labs and H&P to be completed and faxed by 2 PM prior to next day cases. | | | |
| ORDERS (Check all that apply): | | | |
| Routine: <input type="checkbox"/> EKG <input type="checkbox"/> H and H <input type="checkbox"/> K <input type="checkbox"/> BUN <input type="checkbox"/> Creatinine <input type="checkbox"/> Metabolic Panel <input type="checkbox"/> Lipid Panel <input type="checkbox"/> BNP Other: <input type="checkbox"/> CBC <input type="checkbox"/> PT <input type="checkbox"/> PTT <input type="checkbox"/> Platelets <input type="checkbox"/> HIV <input type="checkbox"/> T and C <input type="checkbox"/> T and S <input type="checkbox"/> Mg <input type="checkbox"/> Foley | | | |
| SITE | | | |
| <input type="checkbox"/> Right Femoral <input type="checkbox"/> Left Femoral <input type="checkbox"/> Right Arm <input type="checkbox"/> Left Arm <input type="checkbox"/> Right IJ <input type="checkbox"/> Left IJ <input type="checkbox"/> Art Line | | | |
| DIAGNOSTIC | | | |
| Diagnostic EP <input type="checkbox"/> CEPS <input type="checkbox"/> Single Cath VT Induction <input type="checkbox"/> Partial <input type="checkbox"/> Two Cath Study <input type="checkbox"/> NIPS <input type="checkbox"/> Cath – RH <input type="checkbox"/> Tilt Table <input type="checkbox"/> Biopsy: <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Tilt Table Art Line <input type="checkbox"/> Oximetry | | Ablation <input type="checkbox"/> A-Flutter <input type="checkbox"/> Cryo <input type="checkbox"/> AV Node <input type="checkbox"/> Transeptal <input type="checkbox"/> SVT <input type="checkbox"/> WPW <input type="checkbox"/> VT w / Mapping <input type="checkbox"/> Pulm Vein (A Fib) | |
| | | 3D MAPPING <input type="checkbox"/> ESI <input type="checkbox"/> Navx <input type="checkbox"/> Array <input type="checkbox"/> RMT Carto <input type="checkbox"/> Carto 3 | Navigation <input type="checkbox"/> Tyrex Pouch <input type="checkbox"/> Aquamantis <input type="checkbox"/> Plasma Blade |
| EP/PACEMAKER | | | |
| Pacemaker IMP <input type="checkbox"/> Temp Insertion <input type="checkbox"/> Warranty <input type="checkbox"/> Permanent Single -Org.Implant <input type="checkbox"/> Permanent Dual Date ____ <input type="checkbox"/> Bi Ventricular <input type="radio"/> Lead Replacement <input type="radio"/> Generator Replacement <input type="radio"/> Explant <input type="radio"/> Upgrade to Bi-V <input type="checkbox"/> Leadless Pacemaker | | AICD IMP <input type="checkbox"/> Implant <input type="checkbox"/> Warranty <input type="radio"/> Single -Org.Implant <input type="radio"/> Dual Date ____ <input type="radio"/> Bi-V <input type="radio"/> SCID <input type="checkbox"/> Lead Replacement <input type="checkbox"/> Generator Replacement <input type="checkbox"/> Upgrade to Bi-V <input type="checkbox"/> AICD Check | |
| | | Implant Co. <input type="checkbox"/> Boston <input type="checkbox"/> Medtronic <input type="checkbox"/> St. Jude <input type="checkbox"/> Biotronik <input type="checkbox"/> Impulse Dynamics (CCM) <input type="checkbox"/> Notified <input type="checkbox"/> Y <input type="checkbox"/> N | Other <input type="checkbox"/> TEE Only <input type="checkbox"/> Cardioversion with TEE <input type="checkbox"/> Cardioversion Only <input type="checkbox"/> Anesthesia Needed? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Laser Lead Extraction <input type="checkbox"/> Implantable Loop Recorder <input type="radio"/> Implant <input type="radio"/> Explant <input type="checkbox"/> Reveal <input type="radio"/> Implant <input type="radio"/> Explant <input type="checkbox"/> LAA Closure Device |
| DIAGNOSIS ICD_10 CODES | | CPT PROCEDURE CODES | |
| | | | |
| OTHER ORDERS/INSTRUCTIONS/ADDITIONAL INFO: | | | |
| | | | |

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|------------------------|--------------------------|--------------------------|---------------|
| Metal Implants? | Yes | No | Other: |
| AICD | <input type="checkbox"/> | <input type="checkbox"/> | |
| Pacemaker | <input type="checkbox"/> | <input type="checkbox"/> | |
| Knee | <input type="checkbox"/> | <input type="checkbox"/> | |
| Hip | <input type="checkbox"/> | <input type="checkbox"/> | |
| Aortic Clips | <input type="checkbox"/> | <input type="checkbox"/> | |
| Other _____ | | | |

EP PROCEDURE FORM

