

EPI SCHEDULE FORM

3433 Agler Road, Suite 2400 • Columbus, Ohio 43219 • Phone (614) 428-5553 • Fax (614) 428-5515
 777 W. State Street, Suite 306 • Columbus, Ohio 43222 • Phone (614) 228-0491 • Fax (614) 228-1089

DATE ORDERED: _____	ORDERING PHYSICIAN: _____
CONTACT PERSON: _____	PHYSICIAN'S SIGNATURE: _____
OFFICE PHONE #: _____	
OFFICE FAX #: _____	(Required for diagnostic testing only)
PATIENT NAME: _____	DATE OF BIRTH: _____
HOME PHONE: _____	WORK PHONE: _____

PATIENT'S WEIGHT: _____ **PATIENT'S HEIGHT:** _____ **PATIENT'S BLOOD PRESSURE** _____

TYPE OF APPOINTMENT	LOCATION	ICD-9 CODE	DIAGNOSIS/REASON FOR APPOINTMENT
<input type="checkbox"/> Office visit – New Patient	<input type="checkbox"/> 3433 Agler Road Office	Not Required	
<input type="checkbox"/> Office visit – Patient known to Dr. Guinn			
	<input type="checkbox"/> 777 W. State Street Office		

TYPE OF TEST	LOCATION	ICD-9 CODE	DIAGNOSIS
<input type="checkbox"/> 24 hour Holter monitor	<input type="checkbox"/> 3433 Agler Road Office	780.2	Syncope/Collapse
<input type="checkbox"/> 48 hour Holter monitor		780.4	Dizziness
		427.0	Paroxysmal Supraventricular Tachycardia
		427.31	Atrial Fibrillation
		427.61	Supraventricular Premature Beats
		427.69	Ventricular Premature Beats
	<input type="checkbox"/> 777 W. State Street Office	435.9	Unspecific Transient Cerebral Ischemia (TIA)

TYPE OF TEST/CPT CODES	ICD-9 CODE	DIAGNOSIS
<input type="checkbox"/> Exercise Stress Test	786.51	Precordial Chest Pain
<input type="checkbox"/> Treadmill Myocardial Perfusion (78465, 78478, 78480, J0152)	786.59	Chest Pressure or Tightness
	413.9	Other and Unspec. Angina Pectoris
<input type="checkbox"/> Adenosine Myocardial Perfusion (78465, 78478, 78480, A9500, J0152)	429.3	Cardiomegaly
	V72.81	Pre-Op Evaluation w/High-Risk Factors
<input type="checkbox"/> Exercise Stress Echo (93350, 93320, 93325)	Other	_____

TYPE OF TEST/CPT CODES	ICD-9 CODE	DIAGNOSIS
<input type="checkbox"/> Echocardiogram (93306) Known valve disease? <input type="checkbox"/> Yes <input type="checkbox"/> No	785.2	Heart murmur
	786.05	Shortness of breath, Respiratory distress
	424.0	Valve Disorder - Mitral
	425.4	Other primary Cardiomyopathies
	435.9	Unspec Transient Cerebral Ischemia (TIA)
	Other:	_____

If a referral is needed, please provide the information below or fax the appropriate authorization form. Please submit any necessary documentation to further support the requested testing (EKG, office and or hospital notes, etc.)

Insurance name: _____ **Policy Number:** _____

Referral number: _____ **Date Range:** _____ **Number of visits:** _____

Is patient currently having symptoms? Yes No When did the symptom start? _____

Was an EKG performed? Yes No Date of EKG: _____ Result of EKG: Normal Abnormal

Does patient have any of the following risk factors (circle all that apply)? Diabetes Hypertension Hyperlipidemia Tobacco use Sleep apnea

Family hx of heart disease History of PVD History of renal failure

Has patient had prior heart surgery (circle all that apply)? Angioplasty Bypass Stent placement Valve replacement

Patient Appointment/Test Date: _____ **Arrival Time:** _____