CARDIOLOGY CATHETERIZATION LAB INTAKE FORM

Prior Authorization/Reference# __________________________ Exp. Date of Authorization _______________

Patient’s Phone Number:
Home: __________________________
Cell: __________________________
Work: __________________________

Reason for Catheterization: ___________________________________________________________

ICD 10 (Required): _________________________

Date of Procedure: ___________________________

Type of Catheterization: LHC RHC LHC/RENAL PCI LHC/RHC

Is patient on Warfarin (Coumadin)? YES NO
Is the patient on Apixaban (Eliquis)? YES NO
Is the patient on Rivaroxaban (Xarelto)? YES NO
Is the patient on Edoxaban (Lixiana/Savaysa)? YES NO
Is the patient on Dabigatran (Pradaxa)? YES NO

Referring MD: ____________________________ Phone: ____________________________

Catheterization Scheduler: Catheterization Nurse:
Phone: 847-2862 Phone: 847-6374
Fax: 847-3535 Fax: 847-3031

Ordering Provider Signature Date/Time

Print Name