



## **Rocky Mountain Cardiology** **Consultation and Procedure Request**

Patient Name: \_\_\_\_\_  
Patient Phone #: \_\_\_\_\_

Date: \_\_\_\_\_  
Patient DOB: \_\_\_\_\_

Referring Provider: \_\_\_\_\_

*Please use this form to order diagnostic tests at our office and/or to schedule a consultation with one of our providers.*

Office consult

Diagnostic testing

**Reason for referral:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(Please include copies of recent lab work, ECG, and/or clinic notes, if available)

### **Requested test/s:**

Exercise Treadmill Test

with Nuclear imaging

(Patient weight \_\_\_\_\_)

Adenosine Nuclear Stress Test

(Patient weight \_\_\_\_\_)

24 / 48 Hour Holter Monitor

Echocardiogram

Event Monitor

Carotid ultrasound

Other \_\_\_\_\_

*Please fax this form to our office and give the original to your patient to bring to their appointment.*

### **RMC Boulder**

Ph. 303 442-2395

Fax 303 442-1073

### **RMC Longmont**

Ph. 303 702-5958

Fax 303 702-5960

### **RMC Lafayette**

Ph. 303 604-4646

Fax 303 604-4644