

Greenwich Cardiology Associates

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 203-869-5515

Stress Test Requisition Form

Please fax completed form to:
 203-869-5765

DEMOGRAPHICS:

Patient Name:	Telephone#:
Date of Birth:	Referring Physician:
Patient Weight:	Height:
Primary Insurance:	Policy #:

CLINICAL INFORMATION:

Differential Diagnosis:				
Does the patient have established coronary artery disease (If yes, please indicate which events/exams occurred and when)		No	Yes	Unknown
Exam	Date	Exam		Date
Myocardial infarction		ECG		
Cardiac Catheterization/Coronary CTA		Angioplasty, stenting, or bypass		
Stress Test				
Does the patient have chest discomfort?		No	Yes	Unknown
Does the patient have any additional symptoms?		No	Yes	Unknown
Does the patient smoke?		No	Yes	Unknown
Current blood pressure		Current total cholesterol		
Co-Existing Conditions				
Diabetes		No	Yes	Unknown
Abdominal Aortic Aneurysm		No	Yes	Unknown
Symptomatic peripheral vascular disease		No	Yes	Unknown
History of CVA, TIA, CEA		No	Yes	Unknown
Renal insufficiency/failure		No	Yes	Unknown
Family History of CAD				
Father, brother or son with CAD <50 years old		No	Yes	Unknown
Mother, sister or daughter with CAD <60 years old		No	Yes	Unknown
Is the patient able to walk on a treadmill?		No	Yes	Unknown
Is the exam for pre-operative evaluation?	Surgery Type		Date	