INTERCARE VASCULAR DIAGNOSTIC CENTER

PATIENT INTAKE FORM

TESTING FACILITY NAME: **SITE ID#:**

Address: **Telephone:** **Fax:**

PATIENT DEMOGRAPHICS

First Name: **Last Name:** **Middle Initial:**

Date of Birth: **Sex: M/F** **SSN:** **Race:**

Responsible Party: Patient/Insurance/Other: **Date of Service:**

Name of Insurance: **Patient ID Number:**

Age: **Height :** **Weight:** **BMI:**

I. RISK FACTORS CHECK LIST

Risk Factors	IDENTIFIED	Criteria
Diabetes Mellitus	[ ] Yes[ ] No	Select Yes if patient is under treatment with insulin or oral hypoglycemic agents or if two fasting blood glucose measurements are ≥126 mg/dL.
CVD/ CHD History	[ ] Yes[ ] No	Select Yes if patient has a history of cardiovascular / coronary heart disease.
Atrial Fibrillation Therapy	[ ] Yes [ ] No	Select Yes if patient has a history of atrial fibrillation or irregular heart beat
Hypertensive Therapy	[ ] Yes [ ] No	Select Yes if patient is under antihypertensive therapy or has history of hypertension
Left Ventricular Hypertrophy	[ ] Yes [ ] No	Select Yes if patient has left ventricular hypertrophy on electrocardiogram. Or if the patient has a history of enlarged heart
High Cholesterol	[ ] Yes [ ] No	History of Elevated Blood Lipids. (LDL > 160 mg/dl or HDL < 35 mg/dl or Trig > 300 mg/dl)
Cigarettes Smoking	[ ] Yes [ ] No	Number of cigarettes smoked per day. Includes persons who smoked regularly during the previous 12 months.
Cholesterol	[ ] Yes[ ] No	Enter total and HDL cholesterol in mg/dl.

TEST PERFORMED			INDICATION	
CPT-CODE	**DESCRIPTION**	**RESULT**	**ICD-CODE**	**DIAGNOSIS**
99091	Framingham		401	Hypertension
93922	ABIgram		272	Hyperlipidemia
93923	VASogram		250	Diabetes Mellitus
93923	PADogram		440.29	Atherosclerosis
93924	ENDogram		278	Obesity
82465	Total Cholesterol		443	Peripheral Vascular Disease
83718	HDL Cholesterol		729.5	Leg Pains
83721	LDL Cholesterol		414	Coronary Artery Disease
84478	Triglyceride		428	Heart Failure (Congestive)
82947	Glucose		786.5	Chest Pain
			427	Cardiac dysrhythmias

REFERRAL

TO: INTERCARE VASCULAR DIAGNOSTIC CENTER

Patient Name**:** _____ ID No.: _____

Patient History:

_____

_____

_____

Reasons for referral:

_____

_____

_____

Procedures Needed (Please check)

- ❑ FBMI
- ❑ Vasogram
- ❑ ABI Gram
- ❑ PADOgram
- ❑ All

Requester: Dr. _____

License Number_____

Signature: _____

Received in InterCare Vascular Diagnostic Center: Dr. _____