THE University of Vermont MEDICAL CENTER

MRN

Name

DOB

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:

Phone: 847-2862

Fax: 847-3535

Catheterization Nurse:

Phone: 847-6374

Fax: 847-3031

_____ _____

Ordering Provider Signature Date/Time

_____

Print Name