

**REFERRING PHYSICIAN INFORMATION**

Physician Name: \_\_\_\_\_

Clinic Contact: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**PATIENT INFORMATION –please include demographic sheet with recent office note**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Phone: \_\_\_\_\_

Insurance Authorization: \_\_\_\_\_

**Cardiopulmonary Exercise Test (choose 1):**

- CPET TEST ONLY-include indication below.**  
**\*Filed to patients insurance, facility copay applicable\***
- CPET TEST & SCHEDULE OFFICE EVALUATION with DR. GREEN (after CPET)**  
**\*Filed to patients insurance, facility copay applicable\***
- CPET Screening (Cash Pay option)-no indication needed.**  
**\*\$550 payment due at time of service, includes test and MD consult\***

**Indication for Testing:**

- R06.00-Dyspnea, unspecified
- R06.02-Shortness of breath
- Z79.899-Other long term (current) drug therapy
- I50.9-Heart failure, unspecified
- E85.9-Amyloidosis

**FOR OFFICE USE ONLY:**

CPET Appointment Scheduled: Date \_\_\_\_\_ Time: \_\_\_\_\_

Physician appointment made with: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_