Children's Hospital of Wisconsin®

A member of Children's Hospital and Health System.

Cardiac Catheterization Scheduling Request

Phone: 414-266-2384 Fax: 414-266-3482

Thank you for referring your patient to the Cardiac Catheterization Lab at Children's Hospital of Wisconsin. Please provide the following information and pertinent medical records so we can provide the best and most timely service. Fax this completed form along with pertinent records to 414-266-3482. **This information is required to schedule your patient.**

Patient Information	Referring Provider Information
Patient Name: ______	Provider Name: ______
Parent/Guardian Name: ______	
Patient Address: ______	Provider Address: ______
______	______
Date of Birth: ______	Phone Number: ______
Home Phone Number: ______	Fax Number: ______
Work Phone Number: ______	Cardiologist consulted with: ______
Insurance Carrier: ______	______
Is child in foster care? ☐ No ☐ Yes	

1. Child's diagnosis: ______
2. Medications: ______
3. Is child on: Coumadin? ☐ No ☐ Yes Aspirin? ☐ No ☐ Yes
4. Allergies: ______
5. Weight: ______
6. Type of Catheterization?
   - ☐ Diagnostic
   - ☐ Interventional. Intervention to be done: ______
7. Is this a Pre-Surgical Catheterization? ☐ No ☐ Yes: ______
8. Has the child been hospitalized recently? ☐ No ☐ Yes: ______
9. Has the child had surgery in the past 30 days? ☐ No ☐ Yes: ______

Requested schedule:
- ☐ Within 1 week (REQUIRES PHONE CALL TO 414-266-2384)
- ☐ Within 4 weeks
- ☐ Next available
- ☐ Other: ______

Contact person for confirmation of scheduled date and time: ______

Please send last clinic note, echocardiogram report, all recent and relative images, and any other pertinent medical records. This form and any pertinent medical records can be faxed to 414-266-3482. If there are hard copies of images, please send them to: Children's Hospital of Wisconsin / Attn: Cardiology, MS #713 / 9000 W. Wisconsin Avenue / Milwaukee, WI 53201.

REFERRING PROVIDER SIGNATURE: ______ **DATE/TIME:** ______

OFFICE USE ONLY:

Date Received: ______ **Clinic/MD:** ______

☐ **Referral accepted. Date of appointment:** ______

☐ **Referral denied. Reason:** ______

Schedule confirmed with: ______ **on** ____ /____ /____

Notes: ______

Apply DT Barcode Sticker	
Referral Accepted	DT346
Referral Denied	DT9901

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