NWOCC CHECKLIST FOR CARDIAC CATH

Name _____ Date of Cath _____ _____

DOB _____ SS # _____ Procedure Time _____

Address _____ Booked With _____

_____ Location: TTH ☐ St.V's ☐

Phone _____ St.Luke's ☐ Flower ☐

Diagnosis _____ Other _____

Cath Ordered by Dr. _____ PCP _____ Phone _____

Cathing M.D. _____

Type of Cath:

LV Cor ____ Rt ____ Graft Check ____ Other _____

Prior Cath / Where _____ Cine # _____ Medical Rec # _____

Previous Open Heart / Where _____

Diabetic: Yes ____ No ____ IDDM ____ NIDDM ____ Glucophage: Yes ____ No ____

Anticoagulants: Yes ____ No ____

Allergies _____

Insurance _____ ID/Group # _____

Precert # to call _____

Other insurance _____

Comments:

Patient Education:
Video viewed Yes ____ No ____
Instructions to patient Yes ____ No ____
Instructions mailed Yes ____ No ____

H&P _____ _____
Consent _____
PreCert Notified
Yes ____ No ____ N/A ____
Labs _____ Date _____
Where _____
Pregnancy test Yes ____ No ____
EKG Yes ____ No ____
Chest X-Ray Yes ____ No ____
Ck w/M.D.
Low-Risk Form (St. Luke's) _____
Charge sheet Yes ____ No ____
Added to Pt list _____
Information faxed _____

Scheduled by _____
Date _____