Request for Cardiovascular Services at MercyOne Iowa Heart Center

Fax this form to the MercyOne Iowa Heart Center along with the patient's records (last office notes), demographics and insurance card.

Patient name (First, Middle, Last): _____DOB: _____
Diagnosis for referral: _____Pt phone #:_____
Requesting providers name: _____
Requesting office phone number: _____ Fax number: _____
Primary Care Provider: _____
Patient Insurance: _____
Select preferred Iowa Heart Center appointment location:

- ☐ **Ankeny** P: 515-643-7777 F: 515-643-7781
- ☐ **Ames** P: 515-232-2500 F: 515-246-4479
- ☐ **Carroll** P:712-792-6500 F: 515-246-4481
- ☐ **MercyOne Campus/Laurel St Des Moines** P: 515-235-5000 F: 515-288-6713
- ☐ **Newton** P: 641-841-1400 F: 515-362-4147
- ☐ **Ottumwa** P: 641-682-5349 F: 515-246-4474
- ☐ **West Des Moines** P: 515-633-3600 F: 515-288-0840

Please select all applicable from the following:

- ☐ **Risk Assessment**
- ☐ **Peri-op/Peri-Proc/MRI Cardiac Device Management Recommendations.**
  - **Fax Recommendations to**:_____
- ☐ **Request to re-establish Care** (previous Iowa Heart Center patient)
- ☐ **Request for initial evaluation (new patient) & select services requested:**
- ☐ Cardiology
- ☐ Cardiothoracic Surgery
- ☐ Congenital Heart
- ☐ Heart Failure
  - ☐ Amyloid
  - ☐ Cardio-onoclogy
- ☐ Heart Rhythm Center
- ☐ Peripheral Vascular/Vein
- ☐ Prevention and Wellness
  - ☐ Coronary Calcification
  - ☐ Lipid Management

Complete the following for planned surgical procedures:

Date of surgery: _____Facility location/Name: _____
If unscheduled, select priority: <1 Month 1-3 Months 4-6 Months
Cardiac Reason for risk assessment: _____
Diagnosis for surgery: _____
Surgery/procedure (no abbreviations): _____
Type of anesthetic: _____
Surgeon: _____Surgeon contact number: _____
Surgical Complexity (Circle One): Low/ Mod/ High
Procedural Bleeding Risk (Circle One): Low/ Mod/ High
Medications requested to be held: _____
Additional information/questions: _____
_____

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