



Cardiac Echocardiography Laboratory Order Form
Weill Cornell Medical College – Division of Cardiology
1305 York Avenue, 8th Floor New York, NY 10021
Tel: (646) 962-4733 Fax: (212) 746-8561

**PLEASE PRINT CLEARLY.*

Patient Name: _____ MRN: _____
DOB: _____ Patient's Phone#: _____
Ordering MD: _____ Insurance: _____
MD Phone#: _____ Referral? Yes No
MD Fax#: _____ Authorization# _____

Appointment Date: _____ Time: _____

Please select exam(s) requested:

- Echocardiogram/Doppler Transthoracic
- Echocardiogram/Doppler Transthoracic with Saline Bubble Study
- Congenital Echocardiogram/Doppler Transthoracic
- Stress Echocardiogram

Diagnosis/ICD-9: _____

Referring Physician's Signature: _____ Date of Request: _____

Please fax this completed form to (212) 746-8561, prior to patient's appointment.