

VALLEY DIAGNOSTIC  
IMAGING SERVICES

Olympic Building

**Coronary CT Angiography Patient Questionnaire Sheet**  
**(Patients please fill out before coming in and bring with you to your appointment.)**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Sex: \_\_\_\_\_ Referring Physician: \_\_\_\_\_

Please check all that apply to you:

- |   |   |
|---|---|
| <input type="checkbox"/> Chest pains  | <input type="checkbox"/> Shortness of breath                        |
| <input type="checkbox"/> High blood pressure  | <input type="checkbox"/> Elevated cholesterol                       |
| <input type="checkbox"/> Diabetes   | <input type="checkbox"/> Known heart or vascular disease            |
| <input type="checkbox"/> Smoking (previous or current)                                  | <input type="checkbox"/> Positive or uncertain exercise stress test |
| <input type="checkbox"/> Kidney problems  | <input type="checkbox"/> Asthma or lung disease                     |
| <input type="checkbox"/> Coronary Artery Stent(s):                                      | <input type="checkbox"/> Coronary artery bypass grafts              |
| <input type="checkbox"/> Current or previous pacemaker                                  | <input type="checkbox"/> Heart Valve Replacement(s)                 |
| <input type="checkbox"/> Other chest surgery  | <input type="checkbox"/> Palpitations                               |
| <input type="checkbox"/> Family history of early (before age 50) heart attack or stroke |   |
| <input type="checkbox"/> Pacemaker or Defibrillator                                     | <input type="checkbox"/> Sedentary Lifestyle                        |
| <input type="checkbox"/> Post Menopausal  |   |
| <input type="checkbox"/> Allergy to this/these medication(s) or N/A: _____              |   |

List all medications you are currently taking:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Please indicate if you have had any of the following studies, when & where:

	Location	Date
Exercise stress test	_____	_____
Cardiac echo	_____	_____
Nuclear Medicine heart scan	_____	_____
Cardiac Catheterization	_____	_____
Coronary artery CT	_____	_____
Prior Calcium Score	_____	_____

**CCTA Worksheet – (For Internal Clinic Use- Patients please do not fill out)**

**Check in @** : \_\_\_\_\_ Patient took Lopressor/Verapamil @ \_\_\_\_\_

**Pre-Procedure prep:**

Pulse: \_\_\_\_\_/Regular or Irregular BP: R/L Arm: \_\_\_\_\_ @ \_\_\_\_\_

If pulse  $\geq 70$  AND BP  $\geq 100/70$ , second dose of Lopressor (50mg) or Verapamil (240mg) P.O.

@ \_\_\_\_\_ by \_\_\_\_\_ OR Lopressor (5mg) IV \_\_\_\_\_ by \_\_\_\_\_  
\_\_\_\_\_ EKG lead sticky pads on. 18 Gauge IV in @ \_\_\_\_\_ by: \_\_\_\_\_

**Imaging Room:** @: \_\_\_\_\_

\_\_\_\_\_ 02 2LNC  
\_\_\_\_\_ EKG leads hooked up  
\_\_\_\_\_ Injector set/loaded/hooked up

Calcium score complete @: \_\_\_\_\_ Score= \_\_\_\_\_ Pulse= \_\_\_\_\_

IF score  $> 1000$ , check with CCTA physician before proceeding.

End location: \_\_\_\_\_ cm

Start location: \_\_\_\_\_ cm

\_\_\_\_\_ cm max (optimal = 15cm)

Timing injection: 15ml Visipaque 320 @ 5ml/sec followed by 20ml NS @ 5ml/sec

Time to peak = \_\_\_\_\_ secs (ROI over left sinus of valsalva)

x 2= \_\_\_\_\_ secs

+ 9 secs injection delay

\_\_\_\_\_ =scan delay number (minimum 22)

Pre-Scan Lat \_\_\_\_\_ - \_\_\_\_\_ LOC AP \_\_\_\_\_ - \_\_\_\_\_

**mA:** 450 650 800      **Thickness:** 0.625mm 1.25mm      120kVp

\_\_\_\_\_ Patient receives one dose, 1/150 grain, SL NTG spray.      Scan Pulse: \_\_\_\_\_

Study complete @ \_\_\_\_\_ Reprocess Segment \_\_\_\_\_ Reprocess Burst \_\_\_\_\_

**Post procedure work:**

IV Out @ \_\_\_\_\_ by \_\_\_\_\_ Pulse = \_\_\_\_\_

Supervising CCTA physician: Alla Bauman Block Bowen Klaas Nelsen Yang

VALLEY DIAGNOSTIC  
IMAGING SERVICES

Olympic Building

**CORONARY CT ANGIOGRAPHY SUPPLEMENTAL ORDER**

Preliminary information is required for all CCTA patients, in addition to submitting a general imaging request form with provider's signature. It is important to obtain the following information prior to the patient's scheduled exam time for protocoling of the study and to verify insurance coverage.

**Patient Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Referring Physician Name:** \_\_\_\_\_

**Indication** (please check): The following **clinical scenarios** represent appropriate referrals for CCTA with contrast injections in patients who can tolerate 75-100 ml of iodinated contrast and beta blockers, and who manifest **normal sinus rhythm**:

- acute chest pain and intermediate risk factors but normal or borderline ECG's and cardiac biomarkers, where a negative CCTA will avoid invasive coronary angiography.
- equivocal or discordant or suspected inaccurate stress tests in patients with low/intermediate coronary risk when a negative CCTA will avoid the need for invasive coronary angiography.
- already scheduled for non-coronary cardiac surgery, who are unlikely to have coronary artery disease. These patients must be in sinus rhythm with a slow rate, or be able to tolerate beta blockers.
- suspected/known congenital anomalies of the coronary arteries to assess for surgical suitability.
- planning to undergo atrial fibrillation ablation in whom pulmonary venous and left atrial anatomy is necessary pre-procedure.
- dilated cardiomyopathy, strongly suspected to be non-ischemic and for whom a negative study will avoid cardiac catheterization. These patients must be on beta blockers and be able to tolerate incremental dosing.
- delineation of suspected intracardiac mass/thrombus where echocardiographic assessment has been inconclusive.
- other niche requests such as delineation of coronary bypass grafts, pericardial abnormalities, intracardiac shunts can be approved on a case by case basis.
- screening CCTA (insurance coverage unlikely, payment due day of procedure)

**Other Notes and Requests:** \_\_\_\_\_

***Please fax this form along with related chart notes to 425.656.5552.***