Dear Referring Physician:

Thank you for your interest in the Vanderbilt Autonomic Dysfunction Clinic. Our clinic functions on a consultation basis. Please complete and sign the attached request form for your patient. Your patient may have to stay 1 day for additional testing. We keep all consult requests for 1 month so please fax all requested information promptly.

We have attached an order form for autonomic function test. We must have orthostatic vitals. Please make sure all records are faxed in with appropriately. If not this will delay in the process of reviewing the medical records. The autonomic consultation will certainly be more fruitful if diagnostic test results are available at the time of the patient visit. Our physicians cannot order this testing before they see your patient. Testing ordered in advance of the visit will potentially prevent the patient from having to travel back to Nashville to have testing administered after the consultation. As such, we request you kindly take a look at the attached form and order the autonomic function test (AFT), if you agree (check the appropriate box and provide your signature). The testing will then be scheduled same day as consult, minimizing the need for multiple trips to Vanderbilt for your patient.

Please let me know if you have any questions or concerns.

Thanks,

Regina Allen
Pre Appointment Coordinator
Vanderbilt Autonomic Clinic
Request for Physician  Date ________________

Consultation Services at
VUMC

Fax completed form to 615-936-8208

You have referred _______________________________ DOB __________________________ to the

Autonomic Dysfunction Clinic at the Vanderbilt University Medical Center.

Please complete this form and fax it to the attention of Regina Allen at 615-936-8208.

Indication for Consultation (check all that apply)

__Syncope
__Orthostatic Hypotension (fall in BP>20/10 mmHg within 2 min of standing)
__Orthostatic Tachycardia (increase in HR>30 bpm on standing)
__Other ___________________________

Co-morbidities

__Diabetes Mellitus  __Severe Hypertension
__Parkinson’s disease  __Amyloidosis
__Heart Failure  __Peripheral Neuropathy

Autonomic Consult Requested (pick one)  Orthostatic Vital Signs:
**COMPLETION OF THIS FORM IS REQUIRED PRIOR TO SERVICES BEING RENDERED**

Outpatient Noninvasive Diagnostic Order Form

Ordering Physician Name: __________________________

Patient Name: ______________________________

Ordering Physician Signature: _______________________

Date of Birth: ______________________________

(Physician signature stamp not accepted)

Contact Number: ________________

Diagnostic Testing: (please mark for testing)

(AFT testing required as part of the autonomic evaluation in our clinic. We perform the test as part of the consult visit)

__ Autonomic Function Test including Valsalva Maneuver Study (AFT)

Diagnosis/ICD 10 code: ___________

__Opt out of AFT testing (this may result in a delay in scheduling)

Clinical Summary:

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

Vanderbilt Medical Center
1215 21st Avenue South
Medical Center East South Tower Suite 5209
Nashville, TN 37232-8802
Patient Records Request

Patient Name:

Patient DOB:

To confirm this consult and allow for evaluation of your patient, we will need all records indicated below. Should you have any questions about this request, please call 615-322-2318

Records requested from: DR:

Phone:  
Fax:

☐ DEMOGRAPHIC SHEET  
☐ CLINIC NOTES FOR PAST 3 MONTHS  
☐ COMPLETE HOLTER/EVENT MONITOR REPORTS  
☐ ECHOCARDIOGRAMS AND TEE(TRANS ESOPHAGEAL ECHOCARDIOGRAM) REPORTS-MAIL CD address below (DICOM format preferred)  
☐ STRESS TEST/NUCLEAR TESTING/TREADMILL COMPLETE REPORT MOST RECENT  
☐ CARDIAC CATHETERIZATION REPORT-(MAIL CD address below (DICOM format preferred)  
☐ ADMISSION NOTES/DISCHARGE SUMMARIES  
☐ CAROTID DOPPLER REPORT  
☐ EKG REPORT  
☐ NEUROLOGY/CARDIOLOGY NOTES (PRIORITY)  
☐ MRI BRAIN/HEAD MAIL CD address below (DICOM format preferred)  
☐ EEG/EMG REPORT (IF AVAILABLE)  
☐ SLEEP STUDY REPORT (IF AVAILABLE)  
☐ TILT TABLE/AUTONOMIC FUNCTION TEST (IF AVAILABLE)  
☐ LABS: THYROID FUNCTION TEST, SPEP, UPEP, ACTH STIMULATION TEST, ROUTINE LABS.

PLEASE FAX MEDICAL RECORDS TO:  
PLEASE MAIL DICOM FORMAT DISKS TO:

615-936-8208

Vanderbilt Heart and Vascular Institute  
Attention: Regina Allen  
1215 21st Avenue South  
MCE 5th Floor, South Tower Suite 5209  
Nashville, TN 37232-8802

Confidentiality Notice: This fax transmission is for the sole use of the intended recipient(s) and may contain confidential and privileged information. Any unauthorized review, use, disclose of distribution is prohibited. If you are not the intended recipient, please contact the send at 615-322-2318 and destroy all copies of the original message.
Autonomic Function Testing - A Primer

Autonomic Function Tests including the Valsalva Maneuver (AFT)

These tests involve a series of breathing and blowing maneuvers while continuously monitoring heart rate (continuous ECG) and blood pressure. It also involves a brief 10 minute tilt test.

Quantitative Sudomotor Axonal Reflex Test (QSART)

This test, also called a QSWEAT test, measures sweat response at 4 body sites in response to stimulation. Sweating is mediated by the sympathetic nervous system. This test provides information about the integrity of peripheral sympathetic/autonomic nerves. The test examines the integrity of the postganglionic sympathetic sudomotor axon, assisting in the diagnosis of small fiber neuropathies.

Daxor Total Blood Volume Assessment

This is a Nuclear Medicine test that quantitatively measures blood volume. It involves the injection of a very small amount of 131-I-Human Serum Albumin. Many patients with some disorders, especially orthostatic tachycardia, have a low blood volume that might be a target for treatment.
INSURANCE INFORMATION FORM – PLEASE FILL OUT COMPLETELY
Your patient may require a referral. Please obtain referral prior to visit.

Patient appointment will be cancelled and patient will be notified no authorization obtained by referring MD’s office.

Preauthorization/Referral required? Yes____ No____

Name and number of insurance contact for referral: ____________________________________________
_____________________________________________________________________________________

Authorization/Referral number ______________________

Effective date: ___________ Expires: (date) ________________________________

Number of visits allowed: ___________________________

PLEASE COMPLETE THE FOLLOWING INFORMATION:
Primary Insurance Company______________________________________________________________
Address,____________________________________________________________________________
City________State____Zip_________Phone________________________________
Identification #________________________________
Group#______________________________________

IF POLICY HOLDER IS SOMEONE OTHER THAN THE PATIENT, PLEASE FILL OUT THE FOLLOWING:

Insured’s Name __________________________ Relationship to patient ______________________
DOB_________________ SS#________________________
Address,____________________________________________________________________________
City_________________State____ Zip_________ Phone________________________________

Insured’s employer ____________________ Phone____________________________

Secondary Insurance Company

Address,____________________________________________________________________________
City_________________State____Zip_________ Phone________________________________

Identification #________________________________
Group#______________________________________

Insured’s Name __________________________ Relationship to patient ______________________

Insured’s Name __________________________ Relationship to patient ______________________

DOB_________________ SS#________________________
Address,____________________________________________________________________________
City_________________State____Zip_________ Phone________________________________

Insured’s employer ____________________ Phone____________________________