CORONARY ARTERY CALCIUM SCAN WORKSHEET (SCV/Irwindale Sub-Contractor)

Name:_____ Birthdate: _____ Age in 2 Months: ____

Is employee's Age (in 2 months) ≥40? □ *NO [CAC not indicated]*

□ *YES*

Is employee already taking statins? □ *YES [CAC not indicated]*

□ *NO*

Does employee have one of following? □ +FHx of ASCVD at age <55/65 in 1^{O} male/female

□ 10-year ACC/AHA risk ≥ 5.0

□ *YES*: □ *NO* [*CAC not indicated]*

Is employee willing to consider statins if their CAC is high (>100)?

□ *YES*: □ *NO* [*CAC not indicated]*

Has employee had a CAC in the last three years (or five years if the CAC=0)? → □ *YES* [*CAC not indicated]*

□ *NO:* Complete testing authorization below for CAC at Harbor/UCLA and give to employee.

► Complete testing authorization for CAC at your sub-contractor and give instructions to employee.

► After your clinic receives results, submit the OHP Work Order below for payment. Do not send this page to OHP.

_____ _____ _____

PHYSICIAN SIGNATURE PRINTED NAME DATE

Record Handling: Do not send this page to OHP since it may contain Family History.

Revised 1/27/16

OHP WORK ORDER
CORONARY ARTERY CALCIUM SCAN (A80)
CHIEF EXECUTIVE OFFICE
COUNTY OF LOS ANGELES

Name:_____ Last 4 SSN _____
Last First

Birthdate_____ Dept _____ Dept #_____

Job Title_____ Item #_____

Sub-Contractor Performing CAC Scan: _____

Date CAC Scan Completed: _____

I certify that prior to authorizing this study, I completed the OHP CAC Scan Worksheet, and discussed the possible use of statins with the employee. I have notified the employee of the results of the Scan with my recommendations.

_____ _____ _____
AUTHORIZING PHYSICIAN SIGNATURE PRINTED NAME DATE

Clinic:_____

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Record Handling: Send this page to OHP to ensure payment. Do not send CAC results unless a DMV, HAZMAT, or SCUBA was done concurrently with the Fitness-For-Life evaluation.