

PLEASE INCLUDE A COPY OF THE PATIENT'S INSURANCE CARD AND PERTINENT CLINICAL INFORMATION (We will not be able to schedule your patient without this information. Thank you.)

Patient Name: _____

Patient Phone: _____ Date of Birth: _____

Referral Request Date: _____ No Referral Authorization Required

Primary Insurance: _____ Authorization #: _____ Exp. Date: _____

DIAGNOSIS/REASON FOR REFERRAL:

- | | | |
|--|---|--|
| <input type="checkbox"/> Abnormal EKG (send EKG) | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Peripheral Artery Disease |
| <input type="checkbox"/> Abnormal Stress Test | <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Atrial Fibrillation | <input type="checkbox"/> Dyspnea | <input type="checkbox"/> Syncope/Near Syncope (need EKG) |
| <input type="checkbox"/> Atrial Flutter | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Valve Disorders |
| <input type="checkbox"/> CAD (Coronary Artery Disease) | <input type="checkbox"/> Lipid Management | <input type="checkbox"/> Venous Disease |
| <input type="checkbox"/> Cardiomyopathy | <input type="checkbox"/> Murmur | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Arrhythmias: _____ | <input type="checkbox"/> Pacer/ICD | |
| | <input type="checkbox"/> Palpitations | |

CONSULT:

- | | |
|--|---|
| <input type="checkbox"/> Pre-Op Evaluation/Exam
List Surgery Procedure Info Type,
Date and Surgeon:
_____ | <input type="checkbox"/> Cardiology Consult & Treatment |
| | <input type="checkbox"/> Vascular Consult & Treatment |
| | <input type="checkbox"/> Venous Disease Consult & Treatment |

CONSULT:

- | | |
|---|--|
| <input type="checkbox"/> Echocardiogram 93306 | Lower Extremity: |
| <input type="checkbox"/> Exercise Treadmill Stress Test 93015 | <input type="checkbox"/> Arterial Duplex |
| <input type="checkbox"/> Stress Echocardiogram 93351 | Unilateral - _____ side <input type="checkbox"/> Bilat |
| <input type="checkbox"/> Abdominal Aorta - 93978 | <input type="checkbox"/> Venous Duplex |
| <input type="checkbox"/> Carotid Artery - 93880 | Unilateral - _____ side <input type="checkbox"/> Bilat |
| <input type="checkbox"/> Renal Artery - 93976 | <input type="checkbox"/> Holter Monitoring |
| | <input type="checkbox"/> ABI |

Referring Provider Signature: _____ Date: _____

Referring Provider Printed Name: _____ Fax: _____

Medical Records Needed: Last 5 years – Cardiac and Peripheral Testing (EKG's, ultrasounds, ABI's, etc.) Cardiac/Vascular Surgeries, Last Progress Notes.