CULLMAN REGIONAL

Medical Group

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Phone 256-737-2907
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CARDIOLOGY REFERRAL FORM

Patient name ______________________________

DOB ______________________ Phone ______________________

Height ______________________ Weight ______________________

Address ______________________________

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Primary Insurance ______________________________

Policy ______________________________

Referral authorization # if required ______________________________

Please include clinical documentation such as imaging, lab work, clinic notes, if available.

Please include the following documents

Referral form

Demographic sheet

Insurance referral (if needed)

Office note(s) with documentation for visit

Any previous cardiac testing (especially if abnormal)

DIAGNOSIS/INDICATIONS

☐ Leg Pain
☐ Pulmonary HTN
☐ Palpitation
☐ Shortness of breath
☐ Chest Pain Evaluation
☐ Dizziness
☐ Stroke
☐ Syncope
☐ Peripheral Arterial Disease

☐ Other ______________________ ☐ Allergies ______________________

ORDERING PROVIDER

Physician ______________________________

Phone ______________________ Fax ______________________

Provider Signature ______________________________

Appt. Date and Time ______________________________

Patient notified on ______________________________

Physician offices will be notified when appointments are scheduled and notification is confirmed for all diagnostic procedures

Please include insurance referral, if required.

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