

CARDIOLOGY REFERRAL FORM

Patient name _____

DOB _____ Phone _____

Height _____ Weight _____

Address _____

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

Office note(s) with documentation for visit

Demographic sheet

Any previous cardiac testing (especially if abnormal)

Insurance referral (if needed)

DIAGNOSIS/INDICATIONS

 Leg Pain Shortness of breath Stroke Pulmonary HTN Chest Pain Evaluation Syncope Palpitation Dizziness 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.**

Phone 256-737-2095 · Fax 256-737-2097