CULLMAN REGIONAL

James Lee, MD ***Edward Mahan, MD***
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Cullman, AL 35058
Phone: (256) 737-2907 **FAX: (256) 737-2097**

CARDIOLOGY REFERRAL FORM

Patient's Name: _____

DOB: _____ Phone#: _____ Cell#: _____

Height: _____ Weight: _____

Address: _____

_____

Insurance Carrier: _____

Policy #: _____

Referral authorization # if required _____

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

TESTS REQUESTED (CIRCLE ONE)

CTA Coronary	Nuclear Stress Tests	Interventional Procedure
Ultrasound	ABI	Cardiology Consultation
Echocardiogram	PFT	External Counter Pulsation

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 #: _____

Physician Signature: _____

Appointment Date/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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