



**Heart & Vascular Clinic**  
 1948 Alabama Hwy 157  
 Professional Office Building 1, Suite 230  
 Cullman, AL 35058  
 Phone 256-962-5380  
 Fax 256-737-2097

**Stephen Bakir, MD**  
**Brad Cavender, MD**  
**Chad Colon, MD**  
**John Eagan, MD**  
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## HEART & VASCULAR CLINIC

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

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Leg Pain        | <input type="checkbox"/> Shortness of breath   | <input type="checkbox"/> Stroke                      |
| <input type="checkbox"/> Pulmonary HTN   | <input type="checkbox"/> Chest Pain Evaluation | <input type="checkbox"/> Syncope                     |
| <input type="checkbox"/> Palpitation     | <input type="checkbox"/> Dizziness             | <input type="checkbox"/> Peripheral Arterial Disease |
| <input type="checkbox"/> Other _____     |  |  |
| <input type="checkbox"/> 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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