PATIENT REFERRAL FORM

DOCTOR BILLING #

PHONE FAX

REFERRALS WITH MISSING BILLING NUMBER WILL NOT BE ACCEPTED

NAME

DOB (dd/mm/yy) ADDRESS

HC # TELEPHONE

REASON:

DD/MM/YY

- ☐ NEW CONSULATION
- ☐ FOLLOW UP
- ☐ SPORTS CARDIOLOGY ASSESSMENT

DIAGNOSTIC TESTING:

- ☐ Consult if abnormal results
- ☐ ECG
- ☐ Exercise Stress test
- ☐ Echo (indicate reason):
  - ○ Heart Murmur
  - ○ Native Valvular Stenosis
  - ○ Native Valvular Regurgitation
  - ○ Mitral Valve Prolapse
  - ○ Congenital Cardiac Structural Disease
  - ○ Prosthetic Heart Valves
  - ○ Pericardial Disease
  - ○ Pulmonary Hypertension
  - ○ Chest Pain
  - ○ Dyspnea, Edema, and Cardiomyopathy
  - ○ Hypertension
  - ○ Thoracic Aoric Disease
  - ○ Symptomatic Arrhythmia
  - ○ Before Cardioversion
  - ○ Structural Heart Disease
- ☐ Holter
  - ☐ 24h
  - ☐ 48h
  - ☐ 72h M-Health Patch
  - ☐ 7 days
  - ☐ 14 days

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