Jashvantlal K. Thakkar, M.D., F.A.C.C.

Adult Cardiology

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Telephone (304) 342-8579 Fax (304) 342-8273

Date Referred:_____

Referred BY_____Supervising MD_____

Phone:_____Fax:_____

Referred TO:_____Fax #:_____

Office Address:_____ Phone #:_____

Patient Name_____DOB:_____Gender: F / M

Patient's email address_____

Home Phone:_____Work Phone:_____Cell Phone:_____

Patient's Address:_____

Authorization: ☐Not Required Requested/Pending ☐Requested/Obtained Auth #_____

Primary Medical Insurance:_____Subscriber ID#:_____

Secondary Medical Insurance:_____Subscriber ID#:_____

For Urgent Referrals (need to be seen within a week), **the referring clinician should call the specialist.**

☐**Reason for Referral (Symptoms of Concern)** (also send related medical records or dictated summary)

☐Please advise on the patient's care ☐ Please assume care of this patient

Please ask patient to provide related records from other specialists, if any.

☐**Relevant lab tests and imaging results** (also send related medical records)

☐**Medications and Dosages tried and outcomes** (if not specifically noted in medical records sent with referral)

Please ask patient to bring his/her complete medication list with dosages (or bring the meds themselves) to their appointment.

Appointment is scheduled with:_____on _____at _____arrival time

Prior to appointment please obtain the following information, tests, etc: Date faxed to referring clinician:_____

☐We will contact patient to schedule ☐Please have patient call to schedule ☐Please call patient to schedule