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Adult Cardiology

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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

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