Medical CONSULTANTS
Patient Focused • Quality Oriented • Physician Driven

Cardiology Referral

New Patient Information

Referring physician _____

Referring physician phone number _____ **Do you want called after appt.? ____**

Referring Diagnosis _____

Preferred Cardiologist (otherwise first available)_____

APPOINTMENT PRIORITY ___ Urgent ___ Routine ___ Male ___ Female

Patient name _____

Mailing address (or attach face sheet):

_____

_____

Home phone_____ Cell Phone_____

Date of Birth_____ Social Security number _____

__ Male __ Female Special communication needs for patient?_____

PLEASE FAX MEDICAL RECORDS TO: 765-281-2150

____Recent office note/H&P

____Recent Cardiology testing (Echo, Nuclear Stress test, EKG, etc.)

____Recent Peripheral Vascular testing (Arterial Doppler, CTA, etc.)

____Has the patient recently been hospitalized? Which facility?_____

____ Updated medication list ____ Labs results

____ Patient's insurance cards

MEDICAID	ID#
MEDICARE	ID#
COMMERCIAL (TYPE)	GROUP# ID#
SELF PAY	