

Cardiovascular Referral Fax

Patient Information:

Name _____ DOB: _____

Home Number: _____ Work Number: _____

Insurance Company: _____ Policy Number _____

Referring Physician: _____ Specialty: _____

Referring Physician office Number _____

Fax Number: _____

General Services:

- Cardiology Consultation
- Pre-Operative Evaluation
- Pacemaker Clinic
- Coumadin Clinic (Anticoagulation Management)
- Specialty Clinics (lipid, CHF, Wellness and Prevention)

Diagnosis:

- Abnormal EKG
- Chest Pain/Dyspnea
- Palpitations
- TIA/Stroke
- CHF/Cardiomyopathy
- Syncope/Dizziness
- Heart Murmur
- Edema
- High CV Risk/Family history
- Other _____

Diagnostic Procedures

- | | |
|--|--|
| <input type="checkbox"/> Echocardiogram (Routine Trasthoracic) | <input type="checkbox"/> Transesophageal Echocardiogram |
| <input type="checkbox"/> Treadmill Stress Test (Routine) | <input type="checkbox"/> Cardiac Catheterization |
| <input type="checkbox"/> Nuclear Stress Test: <input type="checkbox"/> Treadmill | <input type="checkbox"/> Pharmacologic (for patients unable to exercise) |
| <input type="checkbox"/> Stress Echocardiogram: <input type="checkbox"/> Treadmill | <input type="checkbox"/> 30 Day event recorder |
| <input type="checkbox"/> 24 hr holter monitoring | <input type="checkbox"/> Ankle Brachial Index (ABI) Vascular Disease Screening |
| <input type="checkbox"/> Carotid Duplex Examination | |

Complimentary ECG consultation for Referring Physicians

Please fax to (678)904-5336

Cardiology Consultants of Atlanta Will promptly schedule requests for service.

Thank You