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Diplomates of the American Boards of Internal Medicine and Cardiovascular Disease

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REFERRAL REQUEST FORM

Patient Name: ______________________ Patient Contact #: ______________

Referring Physician: ______________________ Requested Cardiologist: ______________

Clinical Indication: ____

Status: ☐ STAT ☐ Urgent (within 48 hrs) ☐ Elective

Date: ______________________ Time: ______________________

Requested Services:

- ☐ Consultation
- ☐ Electrocardiogram
- ☐ Echocardiogram, resting, 2-dimensional with Doppler analysis
- ☐ Echocardiogram, resting, 2-dimensional with Doppler analysis and bubble contrast
- ☐ Echocardiogram, transesophageal
- ☐ Holter monitor, 24 hours
- ☐ Holter monitor, 48 hours
- ☐ Event recorder, looping (for syncopal patients)
- ☐ Event recorder, nonlooping (for nonsyncopal patients)
- ☐ Stress test, treadmill ECG
- ☐ Stress test, treadmill ECG with echocardiographic imaging
- ☐ Stress test, treadmill ECG with myocardial perfusion imaging
- ☐ Stress test, Adenosine ECG with myocardial perfusion imaging
- ☐ Ultrasound, carotid arteries
- ☐ Ultrasound, abdominal aorta
- ☐ Ultrasound, extremity, arterial
- ☐ Ultrasound, extremity, venous

Comments: ____

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Referring Physician Signature: ______________________ Date: ______________

Copies to: ____

10/2010