Referral Form

AHVC
ADVANCED HEART & VEIN CENTER

PLEASE INCLUDE A COPY OF THE PATIENT'S INSURANCE CARD AND PERTINENT CLINICAL INFORMATION (We will not be able to schedule your patient without this information. Thank you.)

Patient Name: _____

Patient Phone: _____ Date of Birth: _____

Referral Request Date: _____ ☐ No Referral Authorization Required

Primary Insurance: _____ Authorization #: _____ Exp. Date: _____

DIAGNOSIS/REASON FOR REFERRAL:

- ☐ Abnormal EKG (send EKG)
- ☐ Abnormal Stress Test
- ☐ Atrial Fibrillation
- ☐ Atrial Flutter
- ☐ CAD (Coronary Artery Disease)
- ☐ Cardiomyopathy
- ☐ Arrhythmias: _____
- ☐ Chest Pain
- ☐ Congestive Heart Failure
- ☐ Dyspnea
- ☐ Hypertension
- ☐ Lipid Management
- ☐ Murmur
- ☐ Pacer/ICD
- ☐ Palpitations
- ☐ Peripheral Artery Disease
- ☐ Shortness of Breath
- ☐ Syncope/Near Syncope (need EKG)
- ☐ Valve Disorders
- ☐ Venous Disease
- ☐ Other: _____

CONSULT:

- ☐ Pre-Op Evaluation/Exam
  List Surgery Procedure Info Type, Date and Surgeon: _____
- ☐ Cardiology Consult & Treatment
- ☐ Vascular Consult & Treatment
- ☐ Venous Disease Consult & Treatment

CONSULT:

- ☐ Echocardiogram 93306
- ☐ Exercise Treadmill Stress Test 93015
- ☐ Stress Echocardiogram 93351
- ☐ Abdominal Aorta - 93978
- ☐ Carotid Artery - 93880
- ☐ Renal Artery - 93976

Lower Extremity:

- ☐ Arterial Duplex
  Unilateral - _____ side ☐ Bilat
- ☐ Venous Duplex
  Unilateral - _____ side ☐ Bilat
- ☐ Holter Monitoring
- ☐ ABI

Referring Provider Signature: _____ Date: _____

Referring Provider Printed Name: _____ Fax: _____

Medical Records Needed: Last 5 years – Cardiac and Peripheral Testing (EKG's, ultrasounds, ABI's, etc.) Cardiac/Vascular Surgeries, Last Progress Notes.