California Heart & Vascular Clinic
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CARDIOLOGY NEW PATIENT REFERRAL

Your referral is greatly appreciated. In order for your patient to be seen in our office for a consultation we will require certain medical records. Please fax the medical records requested below as soon as possible before the patient's appointment. If the patient requires prior authorization from his/her insurance please obtain it before the appointment. If medical records are not received prior the visit your patient will be rescheduled.

Patient's Name: ____

Patient's Date of Birth: ______________________ Patient's Phone: ______________

Patient's Insurance: ____

Authorization required? ☐ Yes ☐ No

Referral Date: ______________________ Person calling referral: ______________

Reason for Referral:

Consultation: ____

Regular Treadmill: ____

Treadmill Cardiolite StressTest (If Patient is able to Exercise): ______________________

Adenosine Cardiolite Stress (If Patient is unable to Exercise): ______________________

Echocardiography: ____

Holter: ____

Other Please Explain: ____

Appointment date give: ______________________ Time: ______________

Referring Physician: ____

Phone #: ______________________ Fax: ______________

Please send the following information:

- ☐ Current History & physical, office or hospitalizations
- ☐ Recent progress notes
- ☐ Current medications (Please advise patient to bring medications to appt.)
- ☐ EKG, echo, stress tests or any related tests previously ordered in connection with referral. Lab work, X-rays.

Comments:

CONFIDENTIALITY STATEMENT: IMPORTANT! THE INFORMATION CONTAINED IN THIS FASCIMILE IS INTENEDED ONLY FOR THE PERSONAL AND CONFIDENTIAL USE OF THE DISIGNATEDRECIPIENTS NAMED ABOVE. THIS MESSAGE MAY BE A PHYSICIAN/PATIENT COMMUNICATION AND AS AN AGENT RESPONSIBLE FOR DELIVERING IT TO THE INTENDED RECIPIENT, YOU ARE HEREBY NOTIFIED THAT YOU HAVE RECEIVED THIS DOCUMENT IN ERROR AND THAT ANY REVIEW, DISSEMINATING , DISTRIBUTION OR COPY OF THIS MESSAGE IS STRICTLY PROHIBITED.

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Completed by: