

**REFERRAL FORM**

Please email this form with records to [Referrals@BamaHeartDoc.com](mailto:Referrals@BamaHeartDoc.com)

Referring MD: \_\_\_\_\_ Office Contact: \_\_\_\_\_

Office Phone: \_\_\_\_\_ Office Fax: \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_

We require all of our patients to have a Primary Care Physician.

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Sex: \_\_\_\_\_ Race: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Primary Insurance: \_\_\_\_\_ Contract #: \_\_\_\_\_ Group #: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ Contract#: \_\_\_\_\_ Group#: \_\_\_\_\_

Has the patient seen a cardiologist in the past? If yes, who: \_\_\_\_\_ Please ask patient to request a copy of their medical records to be faxed to our office at (205) 345-4921.

**PLEASE INDICATE REQUEST BELOW:**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Echocardiogram         | <input type="checkbox"/> Stress Echocardiogram | <input type="checkbox"/> Myocardial Perfusion Scan (nuclear stress) |
| <input type="checkbox"/> Carotid Ultrasound     | <input type="checkbox"/> LEA/ABI Duplex        | <input type="checkbox"/> Venous Reflux System (VRS)                 |
| <input type="checkbox"/> Renal Duplex           | <input type="checkbox"/> Aorta Ultrasound      | <input type="checkbox"/> Carotid Ultrasound                         |
| <input type="checkbox"/> Holter Monitor (24 hr) | <input type="checkbox"/> Event Monitor         | <input type="checkbox"/> Consultation                               |

DIAGNOSIS: \_\_\_\_\_

1<sup>st</sup> available appointment (will be with a Nurse Practitioner) or  1<sup>st</sup> appointment must be with Physician

Please fax the following items with this form in order to complete appointment referral.

|  |   |  |
|--|---|--|
| <input type="checkbox"/> Fax cover sheet         | <input type="checkbox"/> Last office visit                | <input type="checkbox"/> \$300 charge for no insurance |
| <input type="checkbox"/> This referral form      | <input type="checkbox"/> Last lab results                 | <input type="checkbox"/> New patient paperwork can be  |
| <input type="checkbox"/> Patient demographics    | <input type="checkbox"/> Last chest xray                  | <b>picked up at the office or download</b>             |
| <input type="checkbox"/> Insurance card/referral | <input type="checkbox"/> Other applicable testing results | <b>on website: bamaheartdoc.com</b>                    |

----- AHVM Internal Use Only -----

Appointment date \_\_\_\_\_ Time \_\_\_\_\_

Testing date \_\_\_\_\_ Time \_\_\_\_\_

Referral received by: \_\_\_\_\_ Date faxed back: \_\_\_\_\_

AHVM to contact patient with appointment. Patient to bring completed new patient paperwork, insurance card(s), driver's license, copay, and their medications in the original bottles to their first visit.