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Referral Date:_____ Referring Doctor:_____

Doctor Phone:_____ Doctor Fax:_____

Patient Name:_____

PHN:_____ DOB:_____ Gender: M F

Home Phone:_____ Cell Phone:_____

Work Phone:_____ Email:_____

Address:_____

Medications:_____

_____

Services requested (please check):

□ **Treadmill test**
(Please include a 12-lead ECG that is less than 3 months old with your referral)

Reason:_____

□ **Holter monitor**
(For patients having symptoms occurring 2 or more times weekly)

Reason:_____

□ **Cardiology consultation**

Cardiologist requested:_____ or □ First Available

Reason:_____

(When requesting a cardiology consultation please include any relevant records with your referral eg: ECGs, blood work, CT scans, MRIs, echocardiograms, treadmill tests, specialist consults etc.)

Please update our office if the urgency of your patient's referral changes. Thank you