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**Referral Form**

905 W. 124th Avenue Unit 150

Westminster, CO 80234

Office: 720-772-8040

**Fax: 720-805-1551**

**\* 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PATIENT PHONE #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Referral Request Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ No Referral Authorization Required □**

Primary Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Authorization #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Exp. Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DIAGNOSIS/REASON FOR REFERRAL:**

□ Abnormal EKG (send EKG)

□ Abnormal Stress Test

□ Arrhythmias \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Atrial Fibrillation

□ Atrial Flutter

□ CAD (Coronary Artery Disease)

□ Cardiomyopathy

□ 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:**

□ Cardiology Consult & Treatment

□ Vascular Consult & Treatment

□ Venous Disease Consult & Treatment

□ Pre-Op Evaluation/Exam

List Surgery Procedure Info Type, Date and Surgeon:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DIAGNOSTIC TESTING:**

**TEST ONLY- please pre-authorize before sending**

□ 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

□ ABI

□ Holter Monitoring □ 24-48hrs □72hrs

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.*