Cardiology Partners

REFERRAL FORM

Specializing in Cardiovascular and Vascular Disease

CARDIAC SERVICES REQUESTED

- ☐ Consult With / Without Testing
- ☐ Stress Echo / Nuclear Stress
- ☐ Echo
- ☐ Holter Monitor / Event Recorder
- ☐ Other (please specify)

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VASCULAR SERVICES REQUESTED

- ☐ Carotid Imaging
- ☐ Abdominal / Renal Vascular Studies
- ☐ Upper / Lower Extremities
- ☐ ABI w/Segmental
- ☐ Vascular Consult

REQUESTED PHYSICIAN

- ☐ James A. Richardson, M.D.
- ☐ Alan M. Taylor II, M.D.
- ☐ Shoaib H. Saya, M.D.
- ☐ Michael D. Venincasa M.D.
- ☐ Levi Rice, Jr., M.D.
- ☐ First Available

PATIENT INFORMATION

Patient Name _____ **Date of Birth** _____

Social Security Number _____ **Home Phone** _____ **Cell** _____

Address _____

Primary Insurance _____ **ID#** _____ **Group** _____

PLEASE INCLUDE COPIES OF INSURANCE CARD IF POSSIBLE.

Diagnosis or Complaints _____

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PLEASE FAX ANY RECENT LAB WORK, EKGS, AND ANY PRIOR CARDIAC TESTING IF AVAILABLE.

Contact Person _____ **Phone** _____

Referring Physician _____

FAX completed form to 817-842-2599

851 Highway 287 N • Mansfield, Texas 76063-2634 • Phone: 817-842-2500 • Fax: 817-842-2599
www.cardiologypartners.com