

CARDIOVASCULAR CONSULTANTS MEDICAL GROUP

Consultative and Interventional Cardiology

Cardiac Electrophysiology

Peripheral Vascular Disease

A Partnership of Medical Corporations

www.healthyhearts.com



Request for Cardiology Services

Today's Date _____

Patient's Name _____ Date of Birth _____

Diagnosis _____ HT: _____ WT: _____

Test(s) Requested:

- | | |
|---|--|
| <input type="checkbox"/> EKG | <input type="checkbox"/> Resting Echocardiogram |
| <input type="checkbox"/> Regular Treadmill Test | <input type="checkbox"/> Stress Echocardiogram |
| <input type="checkbox"/> 24 hour Holter Monitor | <input type="checkbox"/> Dobutamine Echocardiogram |
| <input type="checkbox"/> Event Recorder
<input type="checkbox"/> one week <input type="checkbox"/> two weeks | <input type="checkbox"/> Other: _____ |

****Some PPO insurances now require pre-certification for echocardiography and stress echocardiography (Anthem for example) Please check with the insurance carrier before referring.**

For Nuclear Testing please use the Nuclear Referral Form and give written instruction to patient.

Comments or special instructions:

Referring Physician Signature (required)