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:

- ☐ EKG
- ☐ Resting Echocardiogram
- ☐ Regular Treadmill Test
- ☐ Stress Echocardiogram
- ☐ 24 hour Holter Monitor
- ☐ Dobutamine Echocardiogram
- ☐ Event Recorder
  - □ one week □ two weeks
- ☐ 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)

16542 Ventura Boulevard, Suite 402, Encino, California 91436 Telephone: (818) 782-5041 FAX: (818) 205-9091
14901 Rinaldi Street, Suite 110, Mission Hills, California 91345 Telephone: (818) 365-1339 FAX: (818) 898-4301
100 UCLA Medical Plaza, Suite 410, Los Angeles, California 90024 Telephone: (310) 824-3378 FAX: (310) 208-2870
23929 McBean Parkway, Suite 216, Valencia, California 91355 Telephone: (661) 259-1534 FAX: (661) 284-3670