PROVIDENCE Heart Institute

Referral Request

East Clinics
Phone (503) 962-1000
Scheduling (503) 962-1100

West Clinics
Phone (503) 216-1661
Scheduling (503) 216-1662

Please complete this form and send along with patient demographics, insurance card(s) and records.
Please fax to East (503) 962-1005 or West (503) 216-0950.

Patient last name, first name: _____Date of Birth: _____

Patient Preferred Phone: _____Interpreter needed? Y or N Language: _____

Patient Risk Stratification: ☐ High ☐ Medium ☐ Low

Referral Consult:

Clinical Question_____

_____ Diagnosis Code: _____

Referral Request Priority: ☐ URGENT (1-3 days) ☐ Routine (Next Available)

☐ Next available provider ☐ Specific provider_____ ☐ Specific specialty [select specialty]

Owns communicating referral details to patient/family/caregiver: ☐ Primary Care Provider ☐ Specialist

Care Expectations: ☐Evaluate & Treat ☐Consultation with Co-Mgmt ☐Transfer ☐Second Opinion/Pt Req

Number of visits for referral (optional or as designated by insurance)_____
Referral# (if needed): _____AIM Auth#: _____

Ordering Provider Name: _____ Phone: _____
Primary Care Provider Name:
_____

Diagnostic testing only:

Dx(s) w/ICD-10 code for Diagnostic(s) **(if known):** _____

☐ Holter Monitor:
☐24hr ☐48hr ☐72hr
☐Event Monitor/King of Hearts
☐Zio patch
☐Nuclear Stress Test
☐Exercise ☐Adenosine
☐Carotid Ultrasound
☐Vascular Study: ☐UE ☐LE
☐Arterial ☐Venous
☐EKG only
☐Standard Echocardiogram
☐Stress Echocardiogram
☐Standard Stress Test (TM Only)
☐Ankle Brachial Indices (ABI)
☐Abdominal Aortic Ultrasound
☐Renal Ultrasound

****For Diagnostics, if patient's weight is greater than 350 pounds, please note weight _____****

Please send us the most recent records including:

Please do not send Providence records
Please include patient Name and Date of Birth on ALL pages for legality reasons**

☐ Cardiac symptom related Office Visit note(s) with a Medication/Problem list
☐ Lab(s): Blood work: Lipid, CMP, BMP, CBC, TSH, Protime...
☐ ECG tracing (aka EKG, electrocardiogram) in landscape mode, no screen shots please
☐ Echocardiogram ☐ Chest imaging report ☐ Stress Test ☐ PFT Spirometry ☐ Vascular / Renal Study ☐ Sleep Study report
☐ Please send prior cardiology notes or procedures from other facilities
Facility name(s): _____