PROVIDENCE
Heart Institute

Referral Request

Vascular Surgery
Phone 503-962-1020
Fax: 503-962-1021

Cardiac Surgery
Phone 503-216-8670
Fax 503-216-8699

Please complete and fax this form along with patient demographics, insurance card(s) and records.

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

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

Referral Consult:

Clinical Question_____

_____

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

☐ Next available provider ☐ Specific provider_____ ☐ Specific specialty_____

Number of visits for referral (optional or as designated by insurance)_____

Referral# (if needed): _____AIM Auth#: _____

Printed 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**

☐ Related Office Visit note(s) with a Medication List /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 ☐ Cardiac imaging ☐ Stress Test
☐ PFT / Spirometry ☐ Vascular / Renal Study ☐ Sleep Study report
☐ Please send prior cardiology notes or procedures from other facilities
Facility name(s): _____