FLOW HEART & VASCULAR

Cardiovascular Referral

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FAX 480-571-0269 **PHONE 480-571-1863** Do not email PHI

PRIORITY AND REFERRAL TYPE

☐ Routine ☐ Urgent but stable ☐ Physician discussion requested DATE

PATIENT

FULL NAME | DATE OF BIRTH | PREFERRED LANGUAGE

PHONE | EMAIL | INSURANCE PLAN / MEMBER ID

AUTHORIZATION NUMBER OR STATUS, IF REQUIRED

CLINICAL QUESTION

COMMON INDICATIONS

☐ Chest discomfort / dyspnea ☐ Coronary disease / abnormal test ☐ Palpitations / dizziness / syncope

☐ Valve / structural finding ☐ Peripheral arterial concern ☐ Venous / swelling concern

☐ Second opinion / complex decision ☐ Other

RELEVANT RECORDS INCLUDED

☐ Office note ☐ Medications / allergies ☐ Labs ☐ ECG ☐ Echo / stress reports

☐ Rhythm reports ☐ CT / cath / vascular reports ☐ Actual images or access instructions

☐ Hospital / procedure records IMAGE FACILITY AND STUDY DATE

REFERRING CLINICIAN

NAME AND CREDENTIALS | PRACTICE | NPI (OPTIONAL)

DIRECT PHONE | SECURE FAX | PREFERRED CALLBACK TIME

SIGNATURE | DATE

SEND ROUTINE REFERRALS BY FAX: 480-571-0269

Do not use this form for an emergency. Direct unstable or life-threatening conditions to emergency care or 911.