

ELKHART CLINIC

303 S. Nappanee St. Elkhart, IN 46514
 (574) 296-3200 www.elkhartclinic.com

REFERRAL SERVICE

FAX FORM revised 10/15/10

Date: _____

To: ELKHART CLINIC **From:** _____

Fax: (574) 296-3981 **Fax:** _____

Phone: (574) 296-3979 **Phone:** _____

ELKHART CLINIC USE ONLY

CONFIRMATION OF APPOINTMENT

DOCTOR OR SERVICE _____

APPOINTMENT DATE _____

APPOINTMENT TIME _____

SCHEDULER INITIALS _____

PATIENT NOTIFIED _____ DATE _____

MR# _____

PLEASE PROVIDE THE FOLLOWING PATIENT INFORMATION:

Name: _____ **Birthdate** _____

S.S. # _____ **Parent Name (if minor):** _____

Address: _____ **Phone number between**
 _____ **8 a.m.-5 p.m.** _____

Reason/Diagnosis for referral: _____

Insurance _____

WORK COMP OR AUTO ACCIDENT? _____ **AUTHORIZATION#** _____

Schedule within: 2-3 days 1-2 weeks 3-4 weeks 1st available

<p>Center for Heart Care</p> <ul style="list-style-type: none"> <input type="checkbox"/> Dr. Gonzales <input type="checkbox"/> Dr. W. Lee <input type="checkbox"/> Dr. Nolan <input type="checkbox"/> No Preference <input type="checkbox"/> Surgery Clearance Date of surgery _____ <input type="checkbox"/> Echocardiogram (Resting) <input type="checkbox"/> Exercise Stress Treadmill <input type="checkbox"/> Exercise Stress Echo <input type="checkbox"/> Dobutamine Stress Echo <input type="checkbox"/> Nuclear Stress ____ weight ____ Treadmill ____ Adenosine ____ Dobutamine <input type="checkbox"/> Event Recorder <input type="checkbox"/> Pacemaker Analysis <input type="checkbox"/> Holter Monitor ____24hr____48hr 	<p>Internal Medicine</p> <ul style="list-style-type: none"> <input type="checkbox"/> Dr. Ahuja <input type="checkbox"/> Dr. Buckley <input type="checkbox"/> Dr. Enriquez <input type="checkbox"/> Dr. Fasih <input type="checkbox"/> Dr. Hudson <input type="checkbox"/> Dr. Rogers <input type="checkbox"/> No Preference 	<p>Hematology/ Oncology</p> <ul style="list-style-type: none"> <input type="checkbox"/> Dr. Haque <input type="checkbox"/> Dr. Jin <input type="checkbox"/> Dr. Pletcher <input type="checkbox"/> No Preference 	<p>Gastroenterology</p> <ul style="list-style-type: none"> <input type="checkbox"/> Dr. Arif <input type="checkbox"/> Dr. Karagiannis <input type="checkbox"/> Dr. Raza <input type="checkbox"/> No Preference <input type="checkbox"/> Colonoscopy <input type="checkbox"/> UGI-Endoscopy <input type="checkbox"/> EUS (Endoscopy Ultrasound) <input type="checkbox"/> Capsule Endo (pill camera)
<p>Nutrition Services</p> <ul style="list-style-type: none"> <input type="checkbox"/> Charlotte Weaver 	<p>Allergy</p> <ul style="list-style-type: none"> <input type="checkbox"/> Dr. Rogers 	<p>ENT</p> <ul style="list-style-type: none"> <input type="checkbox"/> Dr. Press <input type="checkbox"/> No Preference <input type="checkbox"/> Audiology- Karen Zigon 	<p>Neurology</p> <ul style="list-style-type: none"> <input type="checkbox"/> Dr. Naeem <input type="checkbox"/> Dr. Vidic <input type="checkbox"/> Dr. Wu <input type="checkbox"/> No Preference <input type="checkbox"/> EEG <input type="checkbox"/> NCS/EMG
	<p>Pulmonary</p> <ul style="list-style-type: none"> <input type="checkbox"/> Dr. Kakish <input type="checkbox"/> Dr. Madappa <input type="checkbox"/> No Preference 	<p>Surgery</p> <ul style="list-style-type: none"> <input type="checkbox"/> Dr. Lester <input type="checkbox"/> Dr. Puster <input type="checkbox"/> No Preference 	<p>Urology</p> <ul style="list-style-type: none"> <input type="checkbox"/> Dr. Guss <input type="checkbox"/> Dr. Rutchik <input type="checkbox"/> No Preference
	<p>Endocrinology</p> <ul style="list-style-type: none"> <input type="checkbox"/> Dr. Knight <input type="checkbox"/> Dr. Murad <input type="checkbox"/> No Preference 	<p>Radiology Services</p> <ul style="list-style-type: none"> <input type="checkbox"/> DEXA Scan <input type="checkbox"/> MRI <input type="checkbox"/> CT Scan <input type="checkbox"/> Ultrasound 	
	<p>Podiatry</p> <ul style="list-style-type: none"> <input type="checkbox"/> Dr. Best 		