

**REFERRAL/ORDER  
FAX FORM**

Date: \_\_\_\_\_

To: ELKHART CARDIOLOGY From: \_\_\_\_\_

Fax: (574) 296-3330

Fax: \_\_\_\_\_

Phone: (574) 296-3466

Phone: \_\_\_\_\_

*ELKHART CARDIOLOGY 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. \_\_\_\_\_  
\_\_\_\_\_

Insurance \_\_\_\_\_

WORK COMP OR AUTO ACCIDENT? \_\_\_\_\_ AUTHORIZATION# \_\_\_\_\_

Schedule within: 2-3 days 1-2 weeks 3-4 weeks 1<sup>st</sup> available

**ELKHART CARDIOLOGY  
PROVIDERS-SUITE A**

- Dr. Gonzales
- Dr. W. Lee
- Dr. Nolan
- No Preference**

- Consult
- Surgery Clearance  
Date of surgery \_\_\_\_\_  
Surgeon \_\_\_\_\_  
PCP \_\_\_\_\_

**ELKHART CARDIOLOGY  
SERVICES-SUITE B**

- Pt's height \_\_\_\_\_ Pt's weight \_\_\_\_\_
- Echocardiogram (Resting)
  - Exercise Stress Treadmill
  - Exercise Stress Echo
  - Dobutamine Stress Echo
  - Nuclear Stress \_\_\_\_\_ weight  
\_\_\_\_\_ Treadmill  
\_\_\_\_\_ Adenosine  
\_\_\_\_\_ Dobutamine
  - Event Recorder
  - Device Analysis
  - Holter Monitor \_\_\_24hr\_\_\_48hr

Name of Ordering Provider (PRINTED) \_\_\_\_\_

Reason/Diagnosis for referral: \_\_\_\_\_

Signature of Ordering Provider: \_\_\_\_\_ Date: \_\_\_\_\_