



Precision Heart Rhythm

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NEW PATIENT REFERRAL FORM

REFERRING PROVIDER

Provider Name: _____

Practice/Clinic: _____

Phone: _____

Fax: _____

PATIENT INFORMATION

Patient Name: _____

DOB: _____

Patient Phone: _____

Insurance: _____

REASON FOR REFERRAL (check all that apply)

- | | |
|--|---|
| <input type="checkbox"/> Atrial Fibrillation / Flutter | <input type="checkbox"/> Syncope / Near Syncope |
| <input type="checkbox"/> SVT | <input type="checkbox"/> Device Evaluation (PPM/ICD/Loop) |
| <input type="checkbox"/> Ventricular Arrhythmia | <input type="checkbox"/> Ablation Consultation |
| <input type="checkbox"/> Bradycardia / Heart Block | <input type="checkbox"/> Medication Management |
| <input type="checkbox"/> Palpitations | <input type="checkbox"/> Other: _____ |

URGENCY

- Routine Semi-Urgent (2-4 weeks) Urgent (<=72 hrs - please call)

ATTACH (if available):

- | | | | |
|--------------------------------------|---|-------------------------------|--|
| <input type="checkbox"/> Office note | <input type="checkbox"/> EKG | <input type="checkbox"/> Echo | <input type="checkbox"/> Monitor |
| <input type="checkbox"/> Stress | <input type="checkbox"/> Cath/EP report | <input type="checkbox"/> Labs | <input type="checkbox"/> Discharge summary |

CLINICAL SUMMARY / QUESTION FOR SPECIALIST

PATIENT CONSENT

- Patient has been informed of this referral and agrees to be contacted.

Referring Provider Signature: _____ Date: _____