

Date: ___/___/___

To begin our assessment the following information is **required**. Please use the form to ensure **ALL REQUIRED** documents are received. Please send the patient's records and demographics (**including a copy of driver's license and insurance card**). The required information and financial clearance must be received **before referrals are processed**. Please fill out form entirely. **Any incomplete or missing information will result in the referral being delayed.**

Patient Information : Name (Mr/Mrs, First-middle-last, Jr/Sr) : _____

Language: _____ Race: _____ Ethnicity: _____ Gender: M F SSN#: _____

Address: _____ City _____ State _____ Zip _____

Phone#: (_____) _____ DOB: _____ Age: ____

Reason for referral: _____ **Diagnosis:** _____

******REQUIRED CLINICAL INFORMATION TO PROCESS THIS REFERRAL******

- Recent H & P Admission & Discharge Summary (within 1 year) Thallium/Stress Test Results
- List of current medications Chemistry/ Hematology Results (Current/within 1 year) CXR, EKG
- Operative reports for Cardiac Procedures within last 5 years
- Cardiac Catheterization Results Most recent ECHO/MUGAS/PTCA

Referring MD: _____ **Specialty:** _____

Address: _____ City _____ State _____ Zip _____

Phone #: (_____) _____ FAX #: (_____) _____ Contact Person: _____

PCP: _____ Address: _____

Phone# (_____) _____ FAX#(_____) _____

Insurance Information: If patient has HMO plan, they must provide copy of referral authorization prior to first appointment.

| | |
|------------------------|------------------------|
| Insurance Co #1: _____ | Insurance Co #2: _____ |
| Insured: _____ | Insured: _____ |
| Insured DOB#: _____ | Insured DOB#: _____ |
| Policy#: _____ | Policy#: _____ |
| Group#: _____ | Group#: _____ |
| Phone# _____ | Phone# _____ |

Has the insurance company been notified of referral? YES NO Authorization #: _____

PLEASE FAX INFORMATION TO: HMT CARDIOLOGY - Case Management Department
5 Tampa General Circle, Ste 300 Tampa, FL 33606
Phone: (813) 844-5582
Fax#: (813) 844-1988

FOR OFFICE USE ONLY

MR#: _____

Referral#: _____

Comments:
