TheHeartGroup
Cardiovascular Associates Inc.

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- Robert Chambers, M.D., F.A.C.C.
- Rimvydas Plenys, M.D.
- Dale Merrill, M.D., F.A.C.C., F.S.C.A.I.
- John Telles, M.D., F.A.C.C., F.H.R.S.
- Dalpinder Sandhu, M.D., F.A.C.C.
- Tejwant Dhillon, M.D., F.A.C.C.
- Alfred Valles, M.D., F.A.C.C., F.S.C.A.I.
- Jagroop Basraon, D.O.
- Jaswant Basraon D.O., M.P.H
- Shaukat Ali M.D., F.A.C.C.

REFERRAL REQUEST FORM

Phone: (559) 492-5749 Fax: (559) 492-5830

SERVICE(S) REQUESTED

Type of Procedure Requested: **Date:**_____

- ☐ Consultation
- ☐ Standard Treadmill
- ☐ Stress Echo
- ☐ Cardiolite with Treadmill Stress
- ☐ Cardiolite with Persantine Stress
- ☐ Echocardiogram
- ☐ Carotid Ultrasound
- ☐ Holter Monitoring
  - ☐ 24 Hour
  - ☐ 48 Hour
- ☐ Cardiac Clearance Pre-Op
  - Procedure _____
  - Diagnosis _____

Priority

☐ ASAP ☐ 24 Hours ☐ 1Wk. ☐ 2Wks. ☐ Next Available ☐ Other_____

Requested Physician:

☐ Any Provider ☐ Robert Chambers ☐ Rimvydas Plenys ☐ Dale Merrill ☐ John Telles ☐ Dalpinder Sandhu

☐ Tejwant Dhillon ☐ Alfred Valles ☐ Jagroop Basraon ☐ Jaswant Basraon ☐ Shaukat Ali

PATIENT INFORMATION

Patient First Name:	**Patient Last Name:**		**D.O.B:**
Home Address:	**City/Town:**	**State:**	**Zip/Postal Code:**
Gender: ☐ M ☐ F	**Patient Home Phone:**	**Patient Work Phone:**	**Patient Cell Phone:**
Patient SSN:	**Patients Employer:**		

PRIMARY INSURANCE

Insurance Company:	
Subscriber Name:	
Insurance ID #:	**Group #:**
Sub ID # or SS#:	

SECONDARY INSURANCE

Insurance Company:	
Subscriber Name:	
Insurance ID #:	**Group #:**
Sub ID # or SS#:	

Referring Doctor:	**Phone:**	**Fax:**
Diagnosis:	**Records to be Sent?**	**Contact Person:**