

- 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.
- Shradha Rathi, M.D.
- Usman Javed, 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: _____

- | | |
|---|---|
| <input type="checkbox"/> Consultation
<input type="checkbox"/> Standard Treadmill
<input type="checkbox"/> Stress Echo
<input type="checkbox"/> Cardiolute with Treadmill Stress
<input type="checkbox"/> Cardiolute with Persantine Stress
<input type="checkbox"/> Echocardiogram
<input type="checkbox"/> Carotid Ultrasound | <input type="checkbox"/> Holter Monitoring
<input type="checkbox"/> 24 Hour
<input type="checkbox"/> 48 Hour
<input type="checkbox"/> 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
 Shradha Rathi
 Usman Javed

PATIENT INFORMATION

Patient First Name:		Patient Last Name:		D.O.B:	
Home Address:			City/Town:	State:	Zip/Postal Code:
Gender: <input type="checkbox"/> M <input type="checkbox"/> 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:	