

- 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.
- Alfred Valles, M.D., F.A.C.C., F.S.C.A.I.
- Jagroop Basraon, D.O.
- Jaswant Basraon D.O., M.P.H., F.A.C.C.
- Shaukat Ali M.D., F.A.C.C.
- Shradha Rathi, M.D., F.A.C.C.
- Usman Javed, M.D., F.A.C.C., R.P.V.I
- Vamshi Gade, M.D., F.A.C.C., F.S.C.A.I, R.P.V.I

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"/> Cardiolite with Treadmill Stress
<input type="checkbox"/> Cardiolite 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
 John Telles
 Dalpinder Sandhu
 Alfred Valles
 Jagroop Basraon
 Jaswant Basraon
 Shaukat Ali
 Shradha Rathi
 Usman Javed
 Vamshi Gade

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:	