TheHeartGroup
Cardiovascular Associates Inc.

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Brandon Woodbury, M.D.

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** ☐ **Rimvydas Plenys** ☐ **Dalpinder Sandhu** ☐ **Jagroop Basraon** ☐ **Jaswant Basraon** ☐ **Shaukat Ali**
☐ **Shradha Rathi** ☐ **Usman Javed** ☐ **Vamshi Gade** ☐ **M. Umair Bakhsh** ☐ **Raj Marok** ☐ **Brandon Woodbury**

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:**