TheHeartGroup
Cardiovascular Associates Inc.
A MEMBER OF COMMUNITY FOUNDATION MEDICAL GROUP & PART OF SANTÉ HEALTH FOUNDATION

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# REFERRAL REQUEST FORM

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

## SERVICE(S) REQUESTED

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

- ☐ Consult
- ☐ Standard Treadmill
- ☐ Stress test with imaging (Consult required)
- ☐ Echocardiogram (current authorization required)
- ☐ Vascular Imaging (current authorization required)
- ☐ 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** ☐ **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:** |