



ASHFORD
CARDIAC CLINIC



ASHFORD
SLEEP CLINIC

REFERRAL FOR CARDIAC AND SLEEP SERVICES

TO DOCTOR

PATIENT NAME DOB | |

ADDRESS

PERIOD OF REFERRAL (MONTHS) 3 6 12 INDEFINITE MEDICARE NUMBER

REASON FOR REFERRAL

1. CARDIOLOGY CONSULTATION 6. REPORT ON ECG
 2. ECHOCARDIOGRAPHY 7. EXERCISE STRESS ECHOCARDIOGRAM
 3. BLOOD PRESSURE MONITORING 8. DOBUTAMINE STRESS ECHOCARDIOGRAM
 4. HOLTER MONITOR (24HR ECG) 9. **HOME SLEEP STUDY AND CONSULTATION**
(Sleep Physician will complete sleep test screening questionnaires)
 5. 12 LEAD ECG WITH REPORT 10. SLEEP PHYSICIAN CONSULTATION

REPORT TO BY SENT BY HealthLink: EDI ashcardi MAIL OR FAX TO:

REFERRING DOCTOR

PROVIDER NUMBER TELEPHONE FACSIMILE

ADDRESS

SIGNATURE DATE | |