



ASHFORD
CARDIAC CLINIC



ASHFORD
SLEEP CLINIC

REFERRAL FOR CARDIAC AND SLEEP SERVICES

TO DOCTOR

PATIENT NAME DOB | |

ADDRESS TELEPHONE

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

REASON FOR REFERRAL

<input type="radio"/> 1. CARDIOLOGY CONSULTATION	<input type="radio"/> 7. REPORT ON ECG
<input type="radio"/> 2. POTS CONSULTATION & ASSESSMENT	<input type="radio"/> 8. EXERCISE STRESS ECHOCARDIOGRAM
<input type="radio"/> 3. ECHOCARDIOGRAPHY	<input type="radio"/> 9. DOBUTAMINE STRESS ECHOCARDIOGRAM
<input type="radio"/> 4. BLOOD PRESSURE MONITORING	<input type="radio"/> 10. HOME SLEEP STUDY AND CONSULTATION <small>(Sleep Physician will complete sleep test screening questionnaires)</small>
<input type="radio"/> 5. HOLTER MONITOR (24HR ECG)	<input type="radio"/> 11. SLEEP PHYSICIAN CONSULTATION
<input type="radio"/> 6. 12 LEAD ECG WITH REPORT	

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

REFERRING DOCTOR

PROVIDER NUMBER TELEPHONE FACSIMILE

ADDRESS

SIGNATURE DATE | |