CookChildren's

Cook Children's locations:

Abilene Alliance Amarilllo Arlington Denton
Fort Worth Mansfield Midland Prosper
San Angelo Southlake Waco Wichita Falls

Cardiology consult/referral request form

Date_____

Patient name _____DOB _____

Patient address_____

Parent or guardian name_____ Parent date of birth_____

Contact numbers home _____ mobile _____

Preferred language _____

Primary insurance name (please send copy of insurance card)_____

Referring physician _____ phone _____ fax _____

Reason for consult/referral (please circle)

Consultation
Outpatient Echocardiogram only
Outpatient Electrocardiogram only
Outpatient 24 hour holter monitor
Sports Electrocardiogram
Other:_____

Reason for referral

Chest Pain
Dyspnea
Heart Murmur
Kawasaki
Ventricular Septal Defect
Atrial Septal Defect/PFO
Abnormal EKG
Syncope
Palpitations
Arrhythmia
Cardiomyopathy
Patent Ductus Arteriosus
Other:_____

Physician signature _____ Date: _____

Before we can schedule an appointment for your patient, we must have this form filled out completely, a copy of the patient's insurance card, labs, imaging, related to cardiology history, patient demographics and clinic note from last visit.

Please fax this form, along with patient pertinent medical records and a copy of the patient's insurance card to **682-885-2329**.

If you have any questions, please contact Cook Children's Heart Center at **682-885-2140.**