PHYSICIAN REFERRAL FORM

Date of Referral _______________

Patient Name ____

Address ____

Telephone ___________________________________ Date of Birth ________________________

Insurance __________________________________ Authorization Needed? Yes _____ No _____

Policy/ID No. ________________________________ Group Name/No. ___________________

Referring Physician ____

Physician Phone ________________________ Physician Fax______________________________

Reason for Referral____

Please include the following records with your referral:

- Authorization / RAF # (if required)
- Office Visit Notes
- Holter / Cardiac / Event / ZIO Monitor (All Strips)
- EKG
- Labs
- TSH / Renal Panel
- Echo / Stress Echo (Strips)
- Nuclear Study

Please fax your referral to (805) 845-6469.

Thank you!