Sibley Heart Center Cardiology Referral Form

Phone: 404-256-2593 or 800-542-2233 Fax: 404-252-7431
choa.org/cardiology

Please ask the patient or parent/guardian to bring this signed form at the time of the visit.

If necessary, generate a referral request from the patient's insurance plan. **Please fax the authorization to 404-252-7431**.

Patient Name: _____ **Date of Birth:** __/__/__ **Patient Phone:** _____

Referring Provider Name:_____ Provider Phone:_____ Provider Fax_____
(please print)

Sibley Heart Center Cardiology

Option 1: Evaluate and Treat ☐

Diagnosis: (Check all that apply)

___ Chest pain
___ Syncope/lightheadedness
___ Palpitations
___ Tachycardia
___ Cardiac Clearance
___ Murmur
___ Cyanotic episodes
___ Hypertension (Send prior BP readings)
___ Hyperlipidemia (Send most recent labs)
___ Abnormal ECG (Send previous ECG)
___ Other _____

Send last clinic notes or other records needed for this appointment.

Option 2: Test Only ☐

Patient will NOT see a Cardiologist

Diagnosis _____

___ ECG (Need previous ECG if available)
___ Echocardiogram
___ Holter Monitor
___ Event Recorder

Orders must be received before a test can be performed.
Fax orders to 404-252-7431.

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Referring Provider Signature: _____ Date: ____/____/____

At Sibley Heart Center Cardiology we have a medical interpreter and language line available to assist all non-English speaking patients.

Please call us at **404-256-2593** or visit **choa.org/orderpad** to request more order pads be sent to your office.