Children's Healthcare of Atlanta Cardiology Referral Form

Phone: 404-256-2593 or 800-542-2233
www.choa.org/heart

Please fax signed form to 404-252-7431.

Authorization Number __________________________ (if needed)

Patient Name: __________________________ Date of Birth: __/__ __ Patient Phone: __________________________

Referring Provider Name: ________________________ Provider Phone: _____________ Provider Fax _____________

(PLEASE PRINT)

Electronic Referral Options
(EPIC or accessCHOA access required - no fax needed)

Option 1: Evaluate and Treat
Cardiology Referral - 99002070MO
*accessCHOA users can attach records to the electronic order

Option 2: Test Only
__ EKG Order - 22000001MO CHR EKG – Children’s Cardiology Clinic
__ Echocardiogram Order - 99002151 CHR ECHOCARDIOGRAM – Children’s Cardiology Clinic

Option 1: Evaluate and Treat ☐

Fax demographic sheet, clinical notes or other records needed for the appointment, with referral to 404-252-7431

Diagnosis: (Check all that apply for full evaluation by Cardiologist)

___ Chest pain
___ Syncope/lightheadedness
___ Tachycardia
___ Cardiac Clearance
___ Murmur
___ Cyanotic Episodes
___ For DX below, send information as indicated:
___ Hypertension (Send prior BP readings)
___ Hyperlipidemia (Send most recent labs)
___ Abnormal ECG (Send previous ECG)
___ Other

Option 2: Test Only ☐

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

Patient will NOT see a Cardiologist

Diagnosis __________________________

Reason for Study __________________________

___ ECG (Need previous ECG if available)
___ Echocardiogram
___ Extended ECG Rhythm Patch - (0-48 hours)
___ Extended ECG Rhythm Patch - (3 days-7 days)
___ Extended ECG Rhythm Patch - (8 days-14 days)

Referring Provider Signature Required: __________________________ Date: __/__ __

Call us to schedule appointment at 404-256-2593
To request more pads to be sent to your office, visit choa.org/orderpad

Cardiology Referral Form. 8/2022