SUMMIT PACIFIC
• MEDICAL CENTER •

Cardiology Clinic Referral Form

Phone: 360-495-5768 **Fax: 360-495-5769**

Patient Information

Height:_____ Weight:_____

Last name:_____ First name:_____ MI:_____ DOB:_____ Age:_____ Sex:_____

Address:_____ City/State:_____ Zip:_____

Home #:_____ Work #:_____ Cell #:_____ Email:_____

Referral Information

Provider:_____ Location:_____ Office Phone:_____

Contact Name:_____ Office Fax:_____

Diagnosis:_____ ICD 10:_____

Primary Insurance:_____ Coverage Eligibility Phone:_____

Member ID #:_____ Group #:_____ Effective Date:_____

Indications:

- ☐ Abnormal EKG
- ☐ CAD / CHF
- ☐ Post PCI
- ☐ F/U known stable CAD
- ☐ Abnormal Stress ECHO
- ☐ Chest Pain
- ☐ Shortness of breath
- ☐ Palpitations / Arrhythmias
- ☐ Edema / PND / Orthopnea
- ☐ Hypertension
- ☐ Cardiovascular risk assessment
- ☐ Syncope / Presyncope / Vertigo / Dizziness
- ☐ Stroke / TIA
- ☐ Other: _____

_____

_____

_____

Does Your Patient Have:

- ☐ Diabetes
- ☐ Asthma
- ☐ Pacemaker
- ☐ ICD

Referral must be submitted with the following information:

- ☐ Patient face sheet
- ☐ List of current medications
- ☐ Surgical and medical history
- ☐ Recent history and physical
- ☐ Recent labs, if available
- ☐ Recent EKG, if available