Coastal Cardiology

Referral Form

Dear Referring Provider,

We have adopted this form to help route incoming requests. We do not require you to use the form. If you do not, please be sure your order includes the same information to route your incoming referral successfully. Referral forms can be returned by fax to 833-613-2634 or by encrypted email to referrals@coastalcardiology.com . Thank you for your kind referral. We appreciate your confidence in our team!

Order for service - circle one:
Consultation Only   **Consultation and treatment with ongoing visits**   **Pre-Operative EKG with surgical cardiac risk assessment, 7-day notice preferred.**   **Pre-Operative EKG only - no risk assessment, 7-day notice preferred.**   *For other diagnostic imaging services please see separate Diagnostic Imaging referral form.*

Patient Name:	**Patient DOB:**
Patient Address:	
Phone Number to Make an Appointment:	

Referral From:		**NPI#:**
Referral Urgency:	□ **Non-Urgent Referral** (*Will be scheduled in the next available slot*)	
	□ **Urgent Referral** (*Every effort is made to get the patient in quickly. If the referring healthcare provider feels this is extremely urgent, please call our on-call cardiologist directly, or leave a cell number here to expedite the referral.* Referring MD Cell Number: ( ) -	
Referral Type:	□ **Consultation Only** (*One visit with recommendations*) Diagnosis: Records to Include: Insurance authorization, if needed, last 2 progress notes, labs, and any relevant imaging.	
	□ **Consultation & Treatment** (*Ongoing Visits*) Diagnosis: Records to Include: Insurance authorization, if needed, last 2 progress notes, labs, and any relevant imaging.	
	□ **Pre-Operative EKG**: □ with risk assessment □ no risk assessment Reason for Surgery: Type of Surgery: Is general anesthesia required? Are medication holds required? Records to Include: Insurance authorization, if needed, and any information relevant to risk assessment.	

Any other relevant information:

Signature of Ordering MD/Provider: _____ **Date:** _____

Order must be signed to be valid. Return form via fax at 833-613-2634 or email referrals@coastalcardiology.com with all required attachments, including insurance cards and any authorization necessary. Thank you!