



RAHMA HEART CARE CLINIC PATIENT REFERRAL FORM

Patient Information:

Last, First name		DOB	Phone
Address			
Insurance, if any			
Referring provider's name		Phone	Fax
Referring facility			
Reason for referral			
Will patient need echo or stress test?	Yes: _____ No: _____	Urgency: Next available: _____	5-7 days: _____

CHECK LIST OF INFORMATION NEEDED FOR REFERRAL		
1.	Most recent clinical notes with cardiac complaint	
2.	Labs within 6 months (if none available, please order fasting lipids & HgbA1c if possible)	
3.	Most recent EKG, Chest X-Ray and any relevant imaging ordered as well as all previous cardiac work ups	
4.	Any other relevant information for cardiology consult	

Please fax this form to: Rahma Heart Care, Fax # (651) 344-0485, If you have any questions please call Phone: (651) 352-3360.
Please do not share this contact information with patients – This phone number is not equipped to address patient concerns.