Alabama Heart & Vascular Medicine
New Patient Referral Form
Email: Referrals@BamaHeartDoc.com

Please Note: We require our patients to have a Primary Care Physician.

Referring MD:_____Office Contact:_____

Office Phone:_____ Office Fax:_____ Primary Care Physician: _____

Patient Name: _____ DOB: _____ Sex: _____ Race: _____

Address:_____City/State/Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Primary Insurance: _____ Contract #: _____ Group #: _____

Secondary Insurance: _____ Contract#: _____ Group#:_____

HAS THE PATIENT SEEN A CARDIOLOGIST IN THE PAST? YES / NO If yes, who: _____
Please request that a copy of these medical records are sent to our office via email or fax (205) 345-4921.

PLEASE INDICATE TESTING OR CONSULTATION NEEDED BELOW:

__ Echocardiogram	__ Stress Echocardiogram	__ Myocardial Perfusion Scan (nuclear stress)
__ Carotid Ultrasound	__ LEA/ABI Duplex	__ Venous Reflux System (VRS)
__ Renal Duplex	__ Aorta Ultrasound	__ Carotid Ultrasound
__ Holter Monitor (24 hr)	__ Zio/Event Monitor	__ Consultation

DIAGNOSIS: _____

Patient Needs Appointment: __ within ONE WEEK __ within 2-3 WEEKS __ within 4-6 WEEKS

Please fax the following items with this form in order to complete appointment referral.

__ Fax cover sheet	**__ Last office visit**	**__ $300 charge for no insurance**
__ This referral form	**__ Last lab results**	**__ New patient paperwork can be**
__ Patient demographics	**__ Last chest xray**	**picked up at the office or download**
__ Insurance card/referral	**__ Other applicable testing results**	**on website: bamaheartdoc.com**

- AHVM Internal Use Only -

Appointment is with _____ Date _____ Time _____

Scheduled testing Date _____ Time_____

Referral Received: _____ Faxed _____ Initials _____

Please contact patient with their appointment information. Have them bring their completed new patient paperwork, their insurance card(s), driver's license, copay, and their medications in the original bottles or an updated medication list