



Patient Referral

Patient Name _____

Date of Birth _____ Patient Phone _____

Ordering Physician _____

Signature of Ordering Physician _____

Physician Fax _____

Consultation

- Type:**
- Cardiology Consultation
 - Electrophysiology Consultation
 - Vascular Consultation

- Please Schedule:**
- Within 24 hours
 - Next Available

Diagnostic Services

Heart

- Nuclear Stress Test
- Echocardiogram
- Stress Echo
- Treadmill Stress Test
- 24-hour holter monitor
- Event Monitor

Vascular

- Carotid Duplex Exam, Bilateral
- Abdominal Aorta
- Extremity Venous
 - Upper: Right Left Both
 - Lower: Right Left Both
- Extremity Arterial
 - Upper: Right Left Both
 - Lower: Right Left Both

Reason for Referral

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Abnormal EKG | <input type="checkbox"/> Cardiomyopathy (obstructive) | <input type="checkbox"/> Lipid management | <input type="checkbox"/> Valve disorders |
| <input type="checkbox"/> Abnormal stress test | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Murmur | <input type="checkbox"/> Vascular disorders |
| <input type="checkbox"/> Arrhythmias | <input type="checkbox"/> Congenital heart disease | <input type="checkbox"/> Pacer defibrillator | |
| <input type="checkbox"/> Atrial fibrillation | <input type="checkbox"/> Congestive heart failure | <input type="checkbox"/> Palpitations | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Atrial flutter | <input type="checkbox"/> Dyspnea | <input type="checkbox"/> Pre-op cardiovascular exam | _____ |
| <input type="checkbox"/> CAD (coronary artery disease) | <input type="checkbox"/> Family history of heart disease | <input type="checkbox"/> Shortness of breath | _____ |
| <input type="checkbox"/> Cardiomyopathy | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Syncope & near syncope | |
| <input type="checkbox"/> Cardiomyopathy (other primary) | | <input type="checkbox"/> Tachycardia | |

Physicians By Location

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Fax: 703.335.8227

Annandale Office

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