SCHEDULING ORDER

HeartPlace BHVH
3409 Worth Street, Suite 500
Dallas, TX 75246
Phone: 214-841-2000
800-841-0422
Fax: 214-821-4774

DATE: _____ TIME: _____

www.heartplace.com

Please fill out completely to expedite your patient referral to HeartPlace. When faxing request, PLEASE send most recent office notes, labs, EKG(s), tests and copy of most recent insurance card. HeartPlace will contact your patient to schedule the visit. We will fax a confirmation of the appointment time to your office. ♡ **STANDARD** (next available appointment) ♡ **URGENT** (within 1-2 days)

PATIENT INFORMATION: ♡ NEW PATIENT ♡ ESTABLISHED PATIENT

NAME: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME PH: _____ WORK PH: _____ CELL PH: _____

SEX: Male Female DOB: _____ SSN: _____

PRIMARY INSURANCE: _____ SECONDARY INSURANCE: _____

INSURANCE #: _____ INSURANCE #: _____

INSURED ID#: _____ GROUP#: _____ INSURED ID#: _____ GROUP#: _____

REFERRAL AUTHORIZATION: _____ REFERRAL COORDINATOR NAME: _____

PHYSICIAN INFORMATION:

NAME: _____ CONTACT PERSON: _____

ADDRESS: _____

OFFICE PH: _____ FAX: _____

DIAGNOSIS: _____

PHYSICIAN'S SIGNATURE: _____

PROCEDURE INFORMATION: Please check requested procedure(s)

Consultation
- ❑ General Cardiology
- ❑ Electrophysiology
- ❑ Interventionalist
- ❑ Cardiothoracic Surgery
- ❑ Peripheral Vascular Disease
- ❑ Specific
- ❑ Varicose Vein

Echocardiography
- ❑ 2D, Doppler Echocardiography

Stress Testing
- ❑ Treadmill Stress Test
- ❑ Stress Echocardiography
- ❑ Pharmacogical Stress Echo

Nuclear Cardiology *
*Paient Weight Required:_____lbs
- ❑ Rest/Exercise SPECT Thallium
- ❑ Lexiscan Nuclear

Arrhythmia Detection
- ❑ EKG
- ❑ Holter Monitor
- ❑ Event Monitor
- ❑ Signal Averaged ECG
- ❑ Pacemaker/Defibrillator Analysis

Vascular Studies

Lower Extremities:
- ❑ Arterial Segmental Pressure (ABI)
- ❑ Arterial Duplex Scan
- ❑ Venous Duplex/Doppler
- ❑ Arterial Exercise Study (ABI)
- ❑ Varicose Vein Study

Upper Extremities:
- ❑ Arterial Duplex Scan
- ❑ Venous Duplex/Doppler
- ❑ Thoracic Outlet Syn

Cerebrovascular:
- ❑ Carotid Sono/Doppler
- ❑ Aorta Duplex Imaging

(Official Use Only)

Patient scheduled for: Date: _____ Time: _____ Confirmation Faxed to Referring Physician: Date: _____ Initials: _____