



Baylor Plano

Consult Referral Request Form

Date: _____

Patient Name: _____

Patient DOB: _____ Patient Phone: _____

Patient Current Diagnosis: _____

Patient Insurance: _____

HeartPlace Physician:

Dr. Samreen Raza

Dr. John Reuter

Dr. Joel Roffman

Dr. Mikko Peter Tauriainen

Dr. Sumeet K. Chhabra

Comments: _____

Please fax **patient demographics, medical records, insurance cards** to the appropriate Clinic Fax Number and include this form as the cover sheet. Your prompt attention to this matter is greatly appreciated. Thank You!!!

Chhabra Fax: **214-254-2259**

Raza, Reuter, Roffman, Tauriainen Fax: **844-292-1461**