HUNTSVILLE HEART SPECIALISTS, LLC
CARDIOVASCULAR / PACEMAKER CONSULTANTS
101 A BOB WALLACE SW @ ALABAMA STREET • HUNTSVILLE, AL 35801

Phone: (256) 963-9483

Fax: (256) 963-9484

NEW PATIENT REFERRAL FORM

Date: ______________________________ Diagnosis: ____

Reason for referral:

- ☐ New Patient Consult
- ☐ Echo
- ☐ Nuclear Stress Test
- ☐ Stress Test
- ☐ EKG
- ☐ Carotid Ultrasound

Patient Name: ____

D.O.B. ______/______/_______ Social Security Number: _______/_______/_________

Address: ____ Phone: _______________________________________

____ Cell: ____

____ Work: ____

Insurance Co: ___________________________ Contract: _________________________ Group: ______________

Secondary Ins. Co: _______________________Contract#_________________________ Group: ______________

Referring Physician Name: ____

Referring Individual NPI: _____________________________ Group NPI:______________________________

Referring Phone: ___________________________________ Referring Fax: ___________________________

Clinic Contact Person: __________________________________

Medicaid, Tricare and select BCBS patients must have PCP Referral or Authorization Attached.

Must Have Copies of ALL Insurance cards, office notes, test results, and imaging studies before patient can be scheduled

(Patient will NOT be scheduled without requested information.)

For Office Use Only:

Appointment Date/Time: ____

Initials: _________________