

21097 N.E. 27th Ct. Suite 580, Aventura, FL, 33180

Referring a Patient

*Denotes Required Field

Patient Information

*Name: _____ *DOB: _____

*Address: _____

*Phone: _____ Alternate Phone: _____

*Social Security# ____ - ____ - ____ *Weight: _____ lbs (*required for stress tests*)

*Insurance: _____ *ID# _____ *Referral or Auth# _____

_____ ID# _____ Referral or Auth# _____

*Referring Physician: _____ *Tel/Fax: _____

*Reason for Referral: _____

***Service Requested Check One:**

	Stress Test	Ultrasound	
	Non-Imaging Treadmill Exercise Test	Echocardiogram	
	Treadmill Stress Echocardiogram (Auth Rq)	Carotid Ultrasound	
	Treadmill Nuclear Exercise Test (Auth Rq)	Lower Extremity Aterial Doppler	
	Persantine Non-Treadmill Nuclear Test (Auth Rq)	Ankle Brachial Index	
	Lexi Scan Stress Echocardiogram (Auth Rq)	Abdominal Aortic Ultrasound	

Appointment Date & Time: _____ **Scheduled by:** _____