Physician Referral Form

Thank you for your referral to Emory Cardiology! We look forward to partnering with you to care for your patient. Please complete the form below and FAX to 404-727-7937.

Patient information		
Patient name:	○ M ○ F	Date of birth:
Street address:		City, state:
Please list contact phone number(s) below		
HOME:	CELL:	WORK:
Interpreter needed?	○ YES ○ NO	Language:
Primary Care Provider (IF DIFFERENT FROM REFERRING):		

This visit is (MARK ONE): ○ **Routine** WITHIN 30 DAYS ○ **Semi-urgent** *WITHIN 2 WEEKS ○ **Urgent** *LESS THAN 48 HOURS

*For urgent appointments, please call 404-778-7777

I am requesting: ○ CONSULT ONLY ○ ONGOING CARE ○ REFERRAL REQUESTED BY PATIENT

Please indicate the physician you'd like this patient to see (_____) or select a sub-specialty below:

○ GENERAL ○ ELECTROPHYSIOLOGY ○ INTERVENTIONAL ○ PREVENTIVE ○ CONGENITAL ○ HEART FAILURE ○ STRUCTURAL

Patient's medical issue

Please indicate specific medical issue to address at this visit:

Please list diagnostic procedures you/your team have completed:

Has the patient had a Cath or ICD/Pacemaker? ○ YES ○ NO

Referring provider information (Please include best information for us to follow-up with you at, and/or request medical records or a referral authorization)

First & Last Name:	Practice Name:
City, state:	Phone no.:
Fax:	Email:
Office contact:	Referring Provider Cell (for physician use only):

Best method to follow up regarding medical records : ○ PHONE ○ EMAIL ○ FAX

Once we receive this form from you, we will contact the patient to schedule an appointment as soon as possible. We will communicate back to the referring provider that the form has been received by Emory Healthcare. If you have questions about this referral, please call Emory Cardiology at 404-778-5299.