# Sibley Heart Center Cardiology Referral Form

**Phone: 404-256-2593 or 800-542-2233 Fax: 404-252-7431**
**www.choa.org/heart**

Please fax signed form to **404-252-7431**.

**Authorization Number**_________________________ **(if needed)**

**Patient Name:**______________________________ **Date of Birth:** __/__/__ **Patient Phone:**____________________

Referring Provider Name:_________________________ Provider Phone:_____________ Provider Fax_____________

**(PLEASE PRINT)**

## Electronic Referral Options

**(EPIC or accessCHOA access required - no fax needed)**

**Option 1: Evaluate and Treat**

Cardiology Referral - 99002070MO
*accessCHOA users can attach records to the electronic order

**Option 2: Test Only**

___ECG Order - CHR EKG Sibley 22000001MO
___Echocardiogram Order - CHR Echo Sibley 99002151

## Option 1: Evaluate and Treat ☐

**Fax demographic sheet, clinical notes or other records needed for the appointment, with referral to 404-252-7431**

**Diagnosis: (Check all that apply for full evaluation by Cardiologist)**

___ Chest pain
___ Syncope/lightheadedness
___ Palpitations
___ Tachycardia
___ Cardiac Clearance
___ Murmur

___ Cyanotic Episodes
For DX below, send information as indicated:
___ Hypertension (**Send prior BP readings**)
___ Hyperlipidemia (**Send most recent labs**)
___ Abnormal ECG (**Send previous ECG**)
___ Other ________________________________

## Option 2: Test Only ☐

**Orders must be received before a test can be performed:**
**Fax this order to 404-252-7431.**

**Patient will NOT see a Cardiologist**

Diagnosis ____________________________________________________________

Reason for Study ______________________________________________________

___ ECG (Need previous ECG if available)
___ Echocardiogram
___ Holter Monitor (24-hour study)
___ Event Recorder (30 day study)

**Referring Provider Signature Required:**_____________________________ **Date:** ____/____/____

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To request more pads to be sent to your office, visit **choa.org/orderpad**

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