Cardiovascular Associates of Greenville

NEW PATIENT REFERRAL REQUEST

To refer a patient, please fax the completed referral order form to **(864) 509-6112**.
We will contact the patient and set up the appointment and send you a confirmation.
Please fax any pertinent office notes/tests with this referral request.

Date of Request: _____ Referring MD: _____

Practice Name: _____ Contact: _____

Phone #: _____ Fax #: _____

Appointment status (please check one): _____ Urgent _____ Within 1-2 weeks _____ Next Available

Reason for referral / diagnoses: _____

Patient Name: Mr. / Mrs. / Ms. _____

Address: _____ City: _____

State: _____ Zip: _____ DOB: _____ Phone #: _____

Insurance: _____ ID#: _____

CONSULTATION: ( ) Cardiac ( ) Vascular

HEART: ( ) Echocardiogram 2D/Doppler/Color

VASCULAR: ( ) Aorta/IVC ( ) Carotid ( ) Renal Artery Duplex ( ) Mesenteric Arteries ( ) ABI

( ) Arterial Duplex: ___ Lower Extremities ___ Upper Extremities

( ) Venous Duplex: ___ Lower Extremities ( ) Bilateral ( ) Unilateral ___ R ___ L

( ) Venous Duplex: ___ Upper Extremities ( ) Bilateral ( ) Unilateral ___ R ___ L

( ) Venous Reflux Standing Vein: ( ) Bilateral ( ) Unilateral ___ R ___ L

MONITORS: ( ) Holter ___ 24 ___ 48 ( ) Event (30 days) ( ) CardioNet (21 days)

( ) Ambulatory BP (24 hr) ( ) Overnight SaO2

SCREENINGS: ( ) ABI ( ) Carotid ( ) Aorta ( ) Echo
