### Referral Request

**NEW LOCATION:**

- **Brier Creek Office**
  - Phone: (984) 215-4540
  - Fax: (984) 215-4541

- **Cary Office**
  - Phone: (919) 387-3260
  - Fax: (919) 919-367-2617

- **Clayton Office**
  - Phone: (919) 359-0322
  - Fax: (919) 359-0326

- **Clinton Office**
  - Phone: (919) 787-5380
  - Fax: (919) 784-5605

- **Garner Office**
  - Phone: (919) 250-2260
  - Fax: (919) 250-2261

- **Goldboro Office**
  - Phone: (919) 734-0033
  - Fax: (919) 734-6999

- **Holly Springs Office**
  - Phone: (919) 787-5380
  - Fax: (919) 784-5605

- **Knightdale Office**
  - Phone: (919) 215-3955
  - Fax: (919) 215-3956

- **Lillington Office**
  - Phone: (910) 814-3201
  - Fax: (910) 814-3207

- **Louisburg Office**
  - Phone: (919) 496-3909
  - Fax: (919) 496-5032

- **Raleigh Office - Rex Main Campus**
  - Phone: (919) 787-5380
  - Fax: (919) 784-5605

- **Rocky Mount Office**
  - Phone: (919) 787-5380
  - Fax: (919) 784-5605

- **Smithfield Office**
  - Phone: (919) 989-7909
  - Fax: (919) 989-3147

- **Wilson Office**
  - Phone: (252) 243-7161
  - Fax: (252) 243-7242

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<th>Cary</th>
<th>Clayton</th>
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**Please fax referral form directly to the requested office.**

**PLEASE SEND PATIENT OFFICE NOTE AT TIME OF FAX REFERRAL**
**-Referral Request-**

Patient's Name: ___________________________ DOB: ___________________________ Male/Female

Address: ___________________________________________________________________________________[_]

Phone: (H) ___________________________ (C) ___________________________ Practice Name: ___________________________

Referring Physician: ___________________________ Fax: ___________________________

Referral Contact: _________________________________________________________________________________

DX: ___________________________ Insurance: ___________________________ Ins. Auth & Exp. Date ___________________________

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<th>Cardiology Consultation</th>
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<th>No</th>
<th>Vascular Consultation</th>
<th>Yes</th>
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<td>If yes, with who? Please circle</td>
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First Available  

If specific office or physician is requested, please see back side of this form.

How soon do you need this consultation?  _____ Days  _____ Weeks  _____ ASAP

**Cardiovascular Testing**

**If requesting only a cardiovascular test, please send office notes, labs and any other cardiac test/procedure results. Please obtain authorization for tests if insurance will allow. Please provide authorization information when requesting any testing to be performed.**

- [ ] Pre-Authorization Obtained
- [ ] Clinic Notes Attached

**Nuclear Imaging:**

- [ ] Treadmill Cardiolite
- [ ] MUGA Scan
- [ ] Lexiscan Cardiolite
- [ ] Dobutamine Cardiolite

**Echocardiography:**

- [ ] Echocardiogram
- [ ] Stress Echocardiogram
- [ ] Bubble Study

If requesting nuclear imaging, please provide the following information:

- Weight: ___________________________
- BP: ___________________________
- Diabetes Y/N
- Smoker Y/N

**Vascular Imaging:**

- [ ] Aortic Duplex
- [ ] Bilateral Carotid
- [ ] Lower Extremity Arterial w/ABI (___Right___Left___Bilateral)
- [ ] Lower Extremity Venous (___Right___Left___Bilateral)
- [ ] Mesenteric Artery Duplex
- [ ] Renal Artery Duplex
- [ ] Upper Extremity Arterial (___Right___Left___Bilateral)
- [ ] Upper Extremity Venous (___Right___Left___Bilateral)

Other:

- 24 Hour (only) Holter Monitor
- 14 Day Event Monitor
- 30 Day Event Monitor
- EKG
- Exercise Treadmill Test

If requesting a test, please sign below:

Physician Signature: ___________________________ Date: ___________________________

1-17-19 PL