Pediatrix Cardiology Associates of New Mexico

Jennifer Davenport, MD
Medical Director
Bharat Dara, MD
Gerard Holmes, MD, PhD
Michelle A. Grenier, MD
Allan James Shapiro, MD

PEDIATRIX CARDIOLOGY

REFERRAL FORM

Date of Request: _____

Patient Name: _____ Date of Birth: _____ Patient SSN: _____

Address: _____ City: _____ State: _____

Responsible Party / Guarantor: _____ Contact Phone: _____

Responsible Party Email Address: _____

Insurance: _____ Subscriber #: _____ Group #: _____

Authorization #: _____

Requesting Provider: _____ Contact Phone: _____

Requesting Provider Email Address: _____

Requesting Provider Signature: _____

SERVICES REQUESTED: (Check all that apply)

- ❑ Consultation
- ❑ Consultation with echocardiogram, if applicable
- ❑ EKG/ECG (electrocardiogram) only
- ❑ Holter monitor
- ❑ Transfer of total care
- ❑ Other services, please specify: _____

_____

_____

_____

INDICATIONS: (Check all that apply)

- ❑ Abnormal EKG (fax copy of EKG)
- ❑ Chest pain
- ❑ Hypertension
- ❑ Irregular heart rate
- ❑ Family history of congenital heart disease
- ❑ Murmur
- ❑ Shortness of breath
- ❑ Suspected / Known fetal abnormality
- ❑ Syncope
- ❑ Other signs or symptoms: _____

_____

PLEASE FAX PERTINENT MEDICAL RECORDS

Phone: 505.848.3700 Fax: 505.848.3703
201 Cedar Street SE, Suite 700, Albuquerque, NM 87106
www.pcanm.com