Dallas Location 621 N. Hall Street Suite 120 Dallas, TX 75226 P: 469-800-7810 F: 469-800-7811

Cardiology Associates

SCHEDULING FORM

Terrell Location 200 N. Virginia Street 1975 Alpha Drive Terrell, TX 75160 P: 469-800-3370

Rockwall Location Suite 204 Rockwall, TX 75087 P: 469-800-3350 F- 460-800-3350

103-000-1011 I	Date:	Time:		1.409-000-3339
Please fill out completely to expedite you EKG(s), tests, and a copy of most recent appointment to your office.	our patient referral to Cardiol t insurance card. We will con NDARD (next available app	ntact your patient to schedule	g request PLEASE send more the visit. We will FAX a con GENT (within 1-2 days)	st recent office notes, lab, onfirmation of the
PATIENT INFORMATION:	□ NEW PATIENT	□ESTABLISHE	D PATIENT	
Name:		,		
Name:		City:	State:	Zip:
Home Phone:	Work Phone:		Cell Phone:	
Sex:	DOB:		_SSN:	
Primary Insurance:		Secondary Insurance	e:	
Insurance#:				
Insured's ID#:G			Groups	#:
	Referral Coordinator:			
Name: Address: Office Phone:				
DIAGNOSIS:PHYSICIAN'S SIGNATURE:				
PROCEDURE INFORMATION: Ple	ase check requested proce	edure(s)		
Consultation ☐ General Cardiology ☐ Electrophysiology ☐ Specific Dr. Request	☐ Treadm ☐ Stress E ☐ Pharma Echoo	Stress Testing Treadmill Stress Test Stress Echocardiography Pharmacologic Stress Echocardiography		nia Detection itor (24 hour) tor Analysis r Analysis Pacemaker
Echocardiography ☐ 2D, Doppler Echocardiography ☐ TEE (Hospital Only)	*Patient Weigh ☐ Rest/Exercise		,	
(Office Use Only)	1-1-10-			
Patient Scheduled For: Procedur	e:	Date:	Time:	

Date:

Initials:

Confirmation Faxed to Referring Physician: