



**Wilmington
Cardiology**

FAX REFERRAL FORM

Wilmington Cardiology, PLLC
1725 New Hanover Medical Park Drive
Wilmington, NC 28403-5345
Phone: 910.815.3420
FAX: 910.815.3876

Linda P. Calhoun, MD	W. Lance Lewis, MD	Mark T. Murphy, MD	Praful N. Patel, MD
James R. Harper Jr., MD	Anthony Maglione, MD	Henry M. Patel, MD	David E. Weaver, MD

Thank you for referring your patient to Wilmington Cardiology! If you prefer to submit your referral by fax instead of telephone, please complete and fax this form, along with the patient's most recent office visit and lab notes, copies of insurance cards, and authorization numbers as applicable. Please note: Incomplete forms may delay confirmation. We will confirm your referral by the end of the next business day.

Referring Physician:				Phone #:			Fax #:			
Faxed by:				Patient's PCP:			Phone #:			
Patient Name:	First	MI	Last	Current/former patient of Wilmington Cardiology?			<input type="checkbox"/> Yes	<input type="checkbox"/> No		
DOB:	/	/		SSN:	-	-	Home #:	Alt. #:		
Street Address:										
City:			State:			ZIP:				
Primary Insurance Carrier:				ID#:		Group#				
Authorization #:			Coverage for:			# Visits:				
Cardiac Diagnoses:	<input type="checkbox"/> Chest Pain			<input type="checkbox"/> Arrhythmia			<input type="checkbox"/> CHF			
	<input type="checkbox"/> Murmur			<input type="checkbox"/> Shortness of Breath			<input type="checkbox"/> Syncope			
	<input type="checkbox"/> Hyperlipidemia			<input type="checkbox"/> Uncontrolled Hypertension			<input type="checkbox"/> Valvular Disease			
	<input type="checkbox"/> Other:			<input type="checkbox"/> Abnormal			Study			
Physician Preference:	<input type="checkbox"/> Calhoun	<input type="checkbox"/> Lewis	<input type="checkbox"/> Murphy	<input type="checkbox"/> P. Patel	<input type="checkbox"/> 1* Available					
	<input type="checkbox"/> Harper	<input type="checkbox"/> Maglione	<input type="checkbox"/> H. Patel	<input type="checkbox"/> Weaver						
Appointment Type (Check one):	<input type="checkbox"/> Consult/Follow-up	<input type="checkbox"/> Echocardiogram	<input type="checkbox"/> Pacer/ICD Follow-up		<input type="checkbox"/> 24-hr. Holter Monitor					
	<input type="checkbox"/> Treadmill Exercise Test	<input type="checkbox"/> Nuclear Stress Test		(Patient's Weight: _____ Lbs)						
Requested Time Frame:	<input type="checkbox"/> URGENT (1-2 Days)			<input type="checkbox"/> 1-2 Weeks			<input type="checkbox"/> Next Available			

CONFIRMATION

We have contacted your patient and scheduled the following appointment:

Date:				Time:	:	<input type="checkbox"/> AM	<input type="checkbox"/> PM	
Provider:	<input type="checkbox"/> Calhoun	<input type="checkbox"/> Harper	<input type="checkbox"/> Lewis	<input type="checkbox"/> Maglione	<input type="checkbox"/> Murphy	<input type="checkbox"/> H. Patel	<input type="checkbox"/> P. Patel	<input type="checkbox"/> Weaver
Questions/Reschedule? Call:				@ 815-3420, ext. #:				