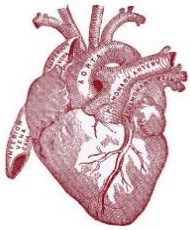

CARDINAL HEART & VASCULAR, PLLC

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PHONE: 919-718-0102
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SURIYA JAYAWARDENA MD, FACC, FASCAI

REFERRAL FORM

PATIENT INFORMATION

FULL NAME: _____

DATE OF BIRTH: _____

ADDRESS: _____

CITY/STATE/ZIP: _____

HOME PHONE: _____

CELL PHONE: _____

SOCIAL SECURITY NUMBER: _____

INSURANCE INFORMATION

PRIMARY INSURANCE: _____
POLICY NUMBER: _____

2ND INSURANCE: _____

2ND INS POLICY NUMBER: _____

DIAGNOSIS INFORMATION

DIAGNOSIS: _____

REASON FOR REFERRAL: _____

REFERRING MD NAME/OFFICE: _____

_____

CONSULTATION SERVICES
*CARDIAC CONSULTATION & TREATMENT
* VASCULAR CONSULTATION & TREATMENT

DIAGNOSTIC TESTING:
* ELECTROCARDIOGRAM (EKG)
* ECHOCARDIOGRAM
* HOLTER MONITORING
* EXERCISE TOLERANCE TEST (ETT)
* EXERCISE NUCLEAR STRESS TEST
* PHARMACOLOGICAL NUCLEAR STRESS TEST -LEXISCAN
* ABI WITH SEGMENTAL PRESSURES
* CAROTID ULTRASOUND
* LOWER EXTREMITY ARTERIAL DUPLEX
* LOWER EXTREMITY VENOUS DUPLEX
* EXERCISE STRESS ECHOCARDIOGRAM

WE APPRECIATE YOUR REFERRAL!

THIS PATIENT HAS BEEN NOTIFIED OF APOINTMENT DATE & TIME.

DATE: _____TIME: _____

EMAIL US AT: CARDINAL2609@GMAIL.COM