TheHeartGroup
Cardiovascular Associates Inc.
A MEMBER OF COMMUNITY FOUNDATION MEDICAL GROUP & PART OF SANTÉ HEALTH FOUNDATION

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- Rimvydas Plenys, M.D.
- Dale Merrill, M.D., F.A.C.C., F.S.C.A.I.
- John Telles, M.D., F.A.C.C., F.H.R.S.
- Dalpinder Sandhu, M.D., F.A.C.C.
- Alfred Valles, M.D., F.A.C.C., F.S.C.A.I.
- Jagroop Basraon, D.O.
- Jaswant Basraon D.O., M.P.H
- Shaukat Ali M.D., F.A.C.C.
- Shradha Rathi, M.D.
- Usman Javed, M.D, F.A.C.C.

REFERRAL REQUEST FORM

Phone: (559) 492-5749 Fax: (559) 492-5830

SERVICE(S) REQUESTED

Type of Procedure Requested: **Date:**____________

☐ Consultation
☐ Standard Treadmill
☐ Stress Echo
☐ Cardiolite with Treadmill Stress
☐ Cardiolite with Persantine Stress
☐ Echocardiogram
☐ Carotid Ultrasound

☐ Holter Monitoring
☐ 24 Hour
☐ 48 Hour
☐ Cardiac Clearance Pre-Op
Procedure ______________________________
Diagnosis ______________________________

Priority

☐ ASAP ☐ 24 Hours ☐ 1Wk. ☐ 2Wks. ☐ Next Available ☐ Other____

Requested Physician:

☐ **Any Provider** ☐ **Robert Chambers** ☐ **Rimvydas Plenys** ☐ **Dale Merrill** ☐ **John Telles** ☐ **Dalpinder Sandhu** ☐ **Tejwant Dhillon**
☐ **Alfred Valles** ☐ **Jagroop Basraon** ☐ **Jaswant Basraon** ☐ **Shaukat Ali** ☐ **Shradha Rathi** ☐ **Usman Javed**

PATIENT INFORMATION

Patient First Name:	**Patient Last Name:**	**D.O.B:**

Home Address:	**City/Town:**	**State:**	**Zip/Postal Code:**

Gender: ☐ M ☐ F	**Patient Home Phone:**	**Patient Work Phone:**	**Patient Cell Phone:**

Patient SSN:	**Patients Employer:**

PRIMARY INSURANCE

Insurance Company:	
Subscriber Name:	
Insurance ID #:	**Group #:**
Sub ID # or SS#:	

SECONDARY INSURANCE

Insurance Company:	
Subscriber Name:	
Insurance ID #:	**Group #:**
Sub ID # or SS#:	

Referring Doctor:	**Phone:**	**Fax:**
Diagnosis:	**Records to be Sent?**	**Contact Person:**