



Referral Information Form

Patient Name: _____ DOB: _____

SSN: _____

Address: _____

Insurance Co: _____

Home phone: _____ Cell/pager: _____

Work phone: _____

Referring MD: _____ Phone: _____

Office contact person: _____ Fax: _____

Diagnosis/reason for referral: _____

Note: Please help us to acquaint ourselves with your patient by providing the following information (if available) at the time of referral:

_____ History and Physical _____ Most recent office notes

_____ Current medication list, including allergies _____ Problem list

_____ Diagnostic tests (cardiac catheterization, echocardiograms, etc.)

Fax or mail to:

Center for Heart Failure Therapy
The Emory Clinic
1365 Clifton Road, NE
Atlanta, GA 30322
Office: (404) 778-5544
Fax: (404) 778-5278

