



## 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 and Transplantation

The Emory Clinic

1365 Clifton Road, NE

Suite AT 430

Atlanta, GA 30322

Office: 404-778-5273

Fax: 404-778-5278