EMORY HEALTHCARE

Thank you for your referral to the Emory Heart Failure Therapy Program.
In order to facilitate your patient's evaluation, please complete this form in its entirety.
It is extremely important to provide the necessary information to expedite the patient's evaluation.

Referral Date: _____
Referring Physician: _____
Referring Address: _____
Diagnosis: _____
Phone Number: _____
Fax Number: _____

Patient Name: (Last): _____ (MI) ____ First: _____
Social Security #: _____ Age: ____
Date of Birth: _____ Sex: ____
Language of Choice: _____ Race: _____
Street Address: _____ Email: _____
City/State: _____ County: _____
Zip: _____ Phone: _____

Emergency Contact: _____
Relationship to Pt: _____
Phone: _____

Patient's Employer: _____ Phone: _____
Occupation: _____ City/State: _____
Address: _____ Zip: _____

Insurance Company: _____
Insurance Subscriber: _____
Policy Number: _____
Group Number: _____
Relationship to Pt: _____
Prior Authorization Required: ☐ Yes ☐ No
Please fax authorization with this form

In order to facilitate your patient's evaluation process, please use this section as a checklist to provide the following records.

History and Physical	☐ Yes	☐ No	_____
Most Recent Office Notes	☐ Yes	☐ No	_____
Current Medication List	☐ Yes	☐ No	_____
Diagnostic Tests	☐ Yes	☐ No	_____
Completed Referral Form	☐ Yes	☐ No	_____
Copy of Insurance Card (Front & Back)	☐ Yes	☐ No	_____
Copy of Driver's License	☐ Yes	☐ No	_____
Your office address, fax & phone numbers	☐ Yes	☐ No	_____

Completed by: _____ Phone: _____
Address: _____ Fax: _____

Once we receive all referral patient information requested on this form, the patient will typically be seen within 2-6 weeks. We will also notify the patient regarding appointment date/time, test results, treatment, diagnostic information. We will provide visit notes to your office using the contact information provided above.

For ETC Purposes Only

Received by: _____ Date: _____