New Hanover Regional Medical Center
Heart Center - Outpatient Services

1415 Physician Drive
Wilmington, NC 28401
Phone: 910.662-9500
FAX: 910.662-9501

Name: _____ _____ _____
(Last Name) (First Name) (Middle Initial)

DOB: _____ MRN#: _____

HAR#: _____ CSN#: _____

CARDIAC FAX REFERRAL/ORDER

Orders preceded by a ☐ will be initiated only if ✔'d.

Patient Name: _____ Date of Birth: _____ SS#: _____
(last 4 digits only)

Address: _____ Contact #: _____ 2nd #: _____
(# where pt can be reached)

Referring provider _____ NPI#: _____

Sender's name: _____ Phone # _____ Fax#: _____

Appointment Type: ☐ Consult ☐ Pacer/ICD ☐ 24 hr Holter Monitor ☐ Followup

***Please include: copy of insurance card, last office visit note, medication list, recent EKG, labs and/or diagnostic tests**

☐ Cardiac clearance for: _____ procedure on _____ date.

Requested Timeframe: ☐ 1-5 days ☐ 2-4 Weeks ☐ Next available

Office Preference: ☐ Wilmington (Main) ☐ Brunswick ☐ Whiteville ☐ Jacksonville

Provider Preference: _____

If an urgent appointment (within 24 hours) is needed, contact a physician at 910-662-9500 to facilitate care for this patient.

Imaging Requested: ☐ Echocardiogram ☐ Stress Echocardiogram ☐ Treadmill Exercise Test
☐ Nuclear Stress Test (Exercise/Pharmacologic as Appropriate) ☐ Carotid/ABI

(Patient's Weight _____ lbs)

Cardiac Diagnoses:
☐ Chest Pain ☐ Abnormal EKG ☐ Chronic Heart Failure (CHF)
☐ Cardiac Murmur ☐ CAD ☐ Syncope ☐ Shortness of Breath
☐ Peripheral Arterial Disease (PAD) ☐ Peripheral Valve Disease (PVD)
☐ Abnormal Study _____ ☐ Valvular Disease _____
(Name study) (Identify valve disease)
☐ Other _____

Primary Insurance
Insurance Co Name: _____
Subscriber#: _____
Group Name/#: _____
Preauthorization #: _____
(if required)

Secondary Insurance
Insurance Co Name: _____
Subscriber#: _____
Group Name/#: _____
Preauthorization #: _____
(if required)

Signature/Credentials: _____ Date: _____ Time: _____

Printed Name: _____

THIS FORM IS PART OF THE PERMANENT MEDICAL RECORD

0064
Physician Order