



Pt Account # _____
CONSULTATION REQUEST

Date: _____
Time: _____
Initials: _____

Patient's Name: _____ M/F

DOB: _____

Patient Address: _____

Home Phone: _____ Work Phone: _____ Best to call: AM/PM

Name of Insurance Carrier: _____

Referring Physician: _____ Phone #: _____

Fax # _____

Contact Person: _____ Primary Physician: _____

Consult Information:

Reason for Consult: _____

If a physician is requested: _____

Does patient have a device? _____ Any previous cardiac surgery? _____ Any previous cardiac history? _____

Pertinent medical records requested: Faxed to: _____

Comments: _____

Appointment Information:

Appointment Date: _____ Time: _____

Physician Assigned: _____ Peoria Pekin Glsbg Satellite _____

Patient has been notified of date and time: Yes No Date: _____

Referring Office Notified: Date Faxed: _____ Spoke to Date: _____

Information Packet Sent: Yes No Date: _____

Signed: _____ Date: _____