



Cardiology consult/referral request form

Before we can schedule an appointment for your patient, we must have this form filled out completely, a copy of the patient's insurance card, labs, imaging related to cardiology history, patient demographics and clinic note from last visit.

Cook Children's locations:

Abilene • Alliance • Amarillo • Arlington • Denton • Fort Worth • Mansfield • Midland • Prosper
San Angelo • Southlake • Waco • Wichita Falls

Date _____

Patient name _____ DOB _____

Patient address _____

Parent or guardian name _____ Parent date of birth _____

Contact numbers: Home _____ Mobile _____

Preferred language _____

Primary insurance name (send copy of insurance card) _____ Member ID _____

Referring physician _____ Phone _____ Fax _____

Please fax this form, along with patient pertinent medical records and a copy of the patient's insurance card to **682-885-2329**.
If you have any questions, please contact Cook Children's Heart Center at **682-885-2140**.

Reason for consult/referral (please circle)

- Consultation
- Outpatient echocardiogram only
- Outpatient electrocardiogram (EKG) only
- Reason for visit: _____
- Outpatient 24 hour Holter monitor
- Other: _____

Physician signature _____ Date _____