



Cardiology consult/referral request form

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 (please send copy of insurance card) _____

Referring physician _____ Phone _____ Fax _____

Reason for consult/referral

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

Reason for referral

- Chest pain
- Dyspnea
- Heart murmur
- Kawasaki
- Other: _____
- Ventricular septal defect
- Atrial septal defect/PFO
- Abnormal EKG
- Syncope
- Palpitations
- Arrhythmia
- Cardiomyopathy
- Patent ductus arteriosus

Physician signature _____ Date _____

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.

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**.