Appointment Referral Request Form

Thank you for your referral. Please complete all fields below.
Refer through EPIC: PHS Dallas

Pediatric Heart Specialists

children's health Care Network Member

Type of Visit:

☐ Cardiology Consult (electrocardiogram (EKG) and/or echocardiogram) ☐ EKG Only*

☐ ECHO Only* ☐ Fetal Consult

Urgency of Appointment: ☐ STAT ☐ Routine

Diagnosis/Reason for Referral: _____

*EKG and ECHO only does not include consult with provider.

Location:

☐ Alliance/Fort Worth ☐ Dallas ☐ Ennis ☐ Flower Mound ☐ Mount Pleasant

☐ Plano ☐ Prosper ☐ Rockwall

Referring Physician Information:

Name: _____

Person Requesting: _____ Phone #: _____ Fax #: _____

Patient Information:

Name: _____ Date of Birth: _____

Address: _____

_____

Parent/Guardian: _____ Date of Birth: _____

Home Number: _____ Work Number: _____ Cell Number: _____

Email: _____ Primary Language: ☐ English ☐ Spanish

Insurance Information:

Insurance Company: _____ Insurance Phone: _____

Guarantor Name: _____ Guarantor Date of Birth: _____

Member ID: _____ Group #: _____

Claims Address: _____

Fax completed form, medical records and copy of your insurance card to 972-331-9833.

pediatricheartspecialists.com

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