

ONE - STEP REFERRAL FORM

FAX REFERRAL GUIDELINES

1. Please send all supporting documentation including cardiac diagnostic reports, medication list, procedures reports, and physician notes.
2. Accepting all private insurances, Personal Injury, Medicare, and Medicaid.
3. Insurance Carrier: _____ Policy/Group # _____
4. Consult and Treat: _____ Diagnostic Testing Only: _____ Consultation Only: _____
5. Diagnosis/Symptoms: _____
6. Choose one of our Locations: Springboro _____ Dayton _____ Eaton _____ Vandalia _____

PATIENT INFORMATION

Patient Name: _____
Social Security #: _____ DOB: _____
Address: _____ Tel: _____

REFERRING PHYSICIAN INFORMATION

Physician Name: _____ ☐ Telephone: _____ ☐ Fax Number: _____
Address: _____
Contact Person: _____

CARDIAC DIAGNOSTIC TEST

- | | |
|---|--|
| ☐ Echocardiography | ☐ Venous Ultrasound |
| ☐ Carotid duplex/ultrasound | ☐ RF Venous Ablation |
| ☐ Abdominal Aortic Aneurysm Screen | ☐ Myocardial Perfusion Imaging |
| ☐ Renal Vascular Ultrasound | ☐ Nuclear Chemical Stress Test |
| ☐ Lower / Upper Ext Arterial Doppler | ☐ Nuclear Treadmill Stress Test |
| ☐ Ankle Brachial Indices | ☐ Regular Treadmill Stress Test |

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