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Physician Referral Order Form

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All insurances are accepted.

Please send a completed referral order form with copies of lab work, EKG, prior cardiac diagnostic results, etc.

PATIENT INFORMATION

Patient Name: ______________________ **DOB:** ____/____/____ **Phone:** ______________________

DIAGNOSTIC **INDICATIONS**

Nuclear Exercise Thallium: ______________________

Nuclear Chemical Stress Thallium: ______________________

Exercise Treadmill Test: ______________________

Exercise Stress Echocardiogram: ______________________

Chemical Stress Echocardiogram: ______________________

Echocardiogram: ______________________

General Ultrasound:

Right Upper Quadrant: ______________ **Abdomen:** ______________

Renal: ______________ **Thyroid:** ______________

ABI / Lower Extremity Arterial Duplex: ______________________

Lower Extremity Venous Duplex: ______________________

Carotid: ______________________

Abdominal Aortic Aneurysm Duplex: ______________________

Renal Artery Duplex: ______________________

Signature of Referring Physician: ______________________

Print Name: ______________________ **Phone:** ______________ **Date:** ____/____/____

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