



REQUEST FOR CONSULTATION

PHYSICIAN REFERRAL SERVICE

HeartSavers Phone: 612-545-5956
HeartSavers Fax #: 612-564-7151
HeartSavers Email: sirvin@heartsavers.me
www.heartsavers.me

REFERRING PHYSICIAN INFORMATION

Date: _____

Referring Physician's Name: _____ UPIN/NPI: _____

Clinic Name: _____

Clinic Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: _____ Fax Number: _____

Contact Name: _____ Contact's Direct #: _____

PATIENT INFORMATION

Gender: Male Female

Name: First _____ Middle _____ Last _____

Address: _____

City: _____ State: _____ Zip Code: _____

County: _____ Date of Birth: _____

Parent's Name (if minor): _____ Spouse's First Name (if any): _____

Previous Name (if any): _____ Home Telephone Number: _____

Work Telephone Number: _____ Mobile Telephone Number: _____

Contact Instructions: [preferred number/best time to reach/OK to leave message] _____

REQUESTED APPOINTMENT

Reason for Referral, Symptoms and Diagnosis: [please be specific and state area of involvement]

Onset/Duration: _____ Pertinent prior surgery or testing (specify dates): _____

Specialty requested: _____ Physician requested (if any): _____

Thank you for allowing us to participate in caring for your patient. We will contact you regarding this referral within 24 hours (or the next business day).