EMORY
HEALTHCARE

Thank you for your referral to the Emory Heart Failure Therapy Program.
In order to facilitate your patient's evaluation, please complete this form in its entirety.
It is extremely important to provide the necessary information to expedite the patient's evaluation.

Referral Date: ______________________
Referring Physician: ______________________
Referring Address: ______________________
Diagnosis: ______________________
Phone Number: ______________________
Fax Number: ______________________

Patient Name: (Last): ______________________ (MI) ____ First: ______________________
Social Security #: ______________________ Age: ____
Date of Birth: ______________________ Sex: ____
Language of Choice: ______________________ Race: ______________________
Street Address: ______________________ Email: ______________________
City/State: ______________________ County: ______________________
Zip: ______________________ Phone: ______________________

Emergency Contact: ______________________
Relationship to Pt: ______________________
Phone: ______________________

Patient's Employer: ______________________ Phone: ______________________
Occupation: ______________________ City/State: ______________________
Address: ______________________ Zip: ______________________

Insurance Company: ______________________
Insurance Subscriber: ______________________
Policy Number: ______________________
Group Number: ______________________
Relationship to Pt: ______________________
Prior Authorization Required: ☐ Yes
Please fax authorization with this form ☐ No

In order to facilitate your patient's evaluation process, please use this section as a checklist to provide the following records.

Record	Yes	No	
History and Physical	☐ Yes	☐ No	______
Most Recent Office Notes	☐ Yes	☐ No	______
Current Medication List	☐ Yes	☐ No	______
Diagnostic Tests	☐ Yes	☐ No	______
Completed Referral Form	☐ Yes	☐ No	______
Copy of Insurance Card (Front & Back)	☐ Yes	☐ No	______
Copy of Driver's License	☐ Yes	☐ No	______
Your office address, fax & phone numbers	☐ Yes	☐ No	______

Completed by: ______________________ Phone: ______________________
Address: ______________________ Fax: ______________________

Once we receive all referral patient information requested on this form, the patient will typically be seen within 2-6 weeks. We will also notify the patient regarding appointment date/time, test results, treatment, diagnostic information. We will provide visit notes to your office using the contact information provided above.

For ETC Purposes Only

Received by: ______________________ Date: ______________________