BARON CARDIOLOGY GROUP, P.C.

Phone: 417-883-5500 Fax: 417-883-5577

# REQUEST FOR CONSULTATION

**Type of Request:** _____ Priority _____ Routine

**Patient Information:**

Name: _____ DOB: _____

Phone: _____ SSN: _____

Address: _____

City/State/Zip: _____

Primary Insurance: _____ Policy #: _____

Secondary Insurance: _____ Policy #: _____

Diagnosis: _____

_____

Internal Cardiac Device: _____ None

_____ Pacemaker (Manufacturer: _____)

_____ ICD (Manufacturer: _____)

_____ Loop Recorder (Manufacturer: _____)

_____ Other (Describe: _____)

**Requester Information:**

Referred By: _____ NPI: _____

Contact Name: _____

Phone #: _____ Fax #: _____

Along with this referral form, please fax a copy of the patient's last office visit note, lab results, and any cardiac testing results (echocardiograms, stress tests, EKGs, Holter monitor (with the rhythm strips), etc.). Upon receipt of the applicable records, we will contact the patient to schedule an appointment, and we will notify your office of the date/time. If you do not hear from us within 1 business day, please call our office to verify we received your fax. Thank you for allowing us to participate in this patient's care.

For Internal Use Only:

Appointment Date: _____ Time: _____