



PALMETTO CARDIOLOGY ASSOCIATES

REFERRAL * FORM

Thank you for choosing to refer your patient to us. To start the referral process, please fax this form back to the attention office scheduling.

Include brief pertinent medical records, including test results that support the consultation

If you require additional assistance, please call (803)252-6644

Date: _____	From: _____
No. of pages: _____	Title: _____
To: PCA _____	Phone: _____
Fax: _____	Fax: _____

PATIENT INFORMATION

Name of patient: _____

DOB: _____ Interpreter needed: Yes No Language: _____

Home phone: _____ Work or cell phone: _____

If child, name of parent: _____

Address: _____

City: _____ Zip: _____

Insurance: Include patient's insurance card (both sides) and HMO authorization if required

CONSULTATION * REQUEST * INFORMATION

Diagnosis/ICD10 _____

Name of PCA MD (if there is preference): _____

Reason for consultation: _____

By providing the information requested and signing below, you agree that we may initiate treatment following consultation or perform medically necessary diagnostics, in association with this consultation. We look forward to collaborating with you on your patient's treatment plan.

REFERRING PHYSICIAN INFORMATION

Referring MD: _____	Specialty: _____
Phone: _____	Fax: _____
PCP name: _____	Phone: _____

Signature: _____

NOTICE OF CONFIDENTIALITY: This is a confidential fax and is intended solely for the person indicated above. If you are not the intended person, you are hereby notified of the confidential nature of this fax and that you are not entitled to read, copy, or otherwise disseminate any of the information contained herein.