



**Heart Specialty Care and Transplant Center
Referral Form**

Appointment Priority:

- Same Day Within a week Within 2-3 weeks More than 3 weeks

Date: _____ Patient Name: _____ D.O.B. _____

Patient Phone: _____ SS#: _____

Diagnosis: _____

Insurance Plan: _____ HMO PPO

Requesting Physician or APN: _____ Phone: _____

Fax: _____

Special Report Instructions: Fax report to: _____ or Call Report to: _____

(Please Arrange for All Medical Records to Be Sent to Seton Heart Specialty Care and Transplant Center)

Services Requested

- Evaluation Heart Transplant Evaluation Advanced Practice Nurse Consultation
 Management Education

Preferred Cardiologist

- Dr. Mary Beth Cishek Dr. Scott Blois
 Dr. John Dieck Dr. David Morris
 Dr. Kara Thompson No Preference

**Main Number (512) 324-3330 Toll Free (800) 686- 4102
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Fax (512) 324-3178
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