FAX

pediatrix | CARDIOLOGY OF THE ROCKY MOUNTAINS

Referral Appointment Request

Please fax referral to 303-839-5844 or email to DenverCardi@pediatrix.com.
Please include clinic notes, labs, and other related records with the referral.

PREFERRED LOCATION (if applicable)

☐ **Presbyterian St. Luke's Office**
2055 High Street, Suite 255
Denver, CO 80205
Phone: 303-860-9933

☐ **Scottsbluff Clinic**
North Medical Plaza
2 West 42nd Street, Suite 1300
Scottsbluff, NE 69361
Phone: 303-860-9933

☐ **Sky Ridge Office**
10099 Ridge Gate Parkway,
Suite 300
Lone Tree, CO 80124
Phone: 303-860-9933

☐ **Greeley Clinic**
1600 23rd Ave.
Greeley, CO 80634
Phone: 303-860-9933

☐ **Avista Clinic**
90 Health Park Dr., Suite 390
Louisville, CO 80027
Phone: 303-860-9933

☐ **Gillette Clinic**
501 South Burma Ave.
Gillette, WY 82716
Phone: 303-860-9933

☐ **Colorado Springs Clinic**
6965 Tutt Blvd., Suite 210
Colorado Springs, CO 80923
Phone: 303-860-9933

☐ **Casper Clinic**
940 E 3rd St., Suite 201
Casper, WY 82601
Phone: 303-860-9933

☐ **Vail Clinic**
180 S. Frontage Rd. West
Vail, CO 81657
Phone: 303-860-9933

☐ **Glenwood Springs Clinic**
1905 Blake Ave., Suite 201
Glenwood Springs, CO 81601
Phone: 303-860-9933

☐ **Loveland Clinic**
2500 Rocky Mountain Ave.,
Suite 100
Loveland, CO 80538
Phone: 303-860-9933

☐ **Fort Collins Clinic**
126 Harvard Street, Suite 1
Fort Collins, CO 80525
Phone: 303-860-9933

☐ **Fort Morgan Clinic**
1000 Lincoln St., Suite 4200
Fort Morgan, CO 80701
Phone: 303-860-9933

REFERRING PROVIDER

Referring Physician or Clinic: _____ Date: _____

Phone: _____ Fax: _____ Contact: _____

PATIENT INFORMATION

Patient Name (First Middle Last): _____ Sex: ☐ Male ☐ Female

DOB (mm-dd-yy) _____ Patient Email (optional) _____ Phone: _____

INSURANCE INFORMATION

Insurer: _____ Plan Name and Number: _____

REQUESTED SERVICES

☐ Pediatric cardiology consultation

☐ EKG

☐ Other _____

_____

_____

INDICATION FOR REFERRAL

☐ Abnormal EKG
☐ Abnormal fetal screen
☐ ADHD screen
☐ Arrhythmia/Palpitations
☐ Cardiomyopathy
☐ Chest pain
☐ Congenital heart disease
☐ Dyspnea FH heart disease
☐ Hypercholesterolemia
☐ Hypertension
☐ Irregular HR
☐ Kawasaki Disease
☐ Murmur
☐ Post COVID clearance
☐ Syncope
☐ Other _____

Physician Signature: _____ Order Date: _____

Appointment Date and Time: _____

Thank you for the opportunity and privilege to care for your patient.