FAX

pediatrix | CARDIOLOGY OF DALLAS

# Referral Appointment Request

**Please fax referral to 972-566-5616.**
Please include clinic notes, labs, and other related records with the referral.

**PREFERRED LOCATION (if applicable)** ☐ Dallas ☐ Frisco ☐ Paris

**PREFERRED PHYSICIAN NAME** ☐ **First Available**

☐ Lee Ann Pearse, MD

## 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.**