

Appointment Referral Request Form



Pediatric
Heart Specialists

Thank you for your referral. Please complete all fields below.
Refer through EPIC: PHS East Texas



Type of Visit: Cardiology Consult Fetal Consult (EDD for Fetal Consults) EKG Only*

Urgency of Appointment: STAT Routine

Diagnosis/Reason for Referral: _____

*EKG only does not include consult with provider.

Location: Tyler Longview

Referring Physician Information:

Name: _____

Person Requesting: _____ **Phone #:** _____ **Fax #:** _____

Patient Information:

Name: _____ **Date of Birth:** _____

Address: _____

Parent/Guardian: _____ **Date of Birth:** _____

Home Number: _____ **Work Number:** _____ **Cell Number:** _____

Email: _____ **Primary Language:** English Spanish

Insurance Information:

Insurance Company: _____ **Insurance Phone:** _____

Guarantor Name: _____ **Guarantor Date of Birth:** _____

Member ID: _____ **Group #:** _____

Claims Address: _____

Subscriber Name: _____ **Subscriber Date of Birth:** _____

Fax completed form, medical records (including labs, electrocardiogram (EKG) and echocardiogram report), demographic information and copy of your insurance card to 903-508-6154.

pediatricheartspecialists.com