EMORY HEALTHCARE

The Emory Adult Congenital Heart (EACH) Center
Patient Self-Referral Form

Contact Information

Name: _____ Date of Birth: _____ Gender: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Alternate Contact (e.g., a spouse, sibling or parent): _____

Employer: _____

Health Insurance: _____

Congenital Heart Disease History

Defect or Diagnosis: _____

Pediatric Cardiologist: _____

Practice Location: _____ Date of Last Visit: _____

Other Cardiologist: _____ Practice Location: _____

Practice Location: _____ Date of Last Visit: _____

Pacemaker or Implantable Cardiac Defibrillator (ICD)? _____ If So, Date of Last Service: _____

Surgical History

Operation Type	Date of Operation	Surgeon	Hospital

Fax the completed form to the EACH Center at 404-778-5035.
Call 404-778-5036 to schedule your initial appointment.