

# EMORY HEALTHCARE

**Thank you for your referral to the Emory Heart Failure Therapy Program.  
In order to facilitate your patient's evaluation, please complete this form in its entirety.  
It is extremely important to provide the necessary information to expedite the patient's evaluation.**

Referral Date: \_\_\_\_\_  
 Referring Physician: \_\_\_\_\_  
 Referring Address: \_\_\_\_\_  
 Diagnosis: \_\_\_\_\_  
 Phone Number: \_\_\_\_\_  
 Fax Number: \_\_\_\_\_

Patient Name: (Last): _____	(MI)	First: _____
Social Security #: _____		Age: _____
Date of Birth: _____		Sex: _____
Language of Choice: _____		Race: _____
Street Address: _____		Email: _____
City/State: _____		County: _____
Zip: _____		Phone: _____

Emergency Contact: \_\_\_\_\_  
 Relationship to Pt: \_\_\_\_\_  
 Phone: \_\_\_\_\_

Patient's Employer: _____	Phone: _____
Occupation: _____	City/State: _____
Address: _____	Zip: _____

Insurance Company: \_\_\_\_\_  
 Insurance Subscriber: \_\_\_\_\_  
 Policy Number: \_\_\_\_\_  
 Group Number: \_\_\_\_\_  
 Relationship to Pt: \_\_\_\_\_

Prior Authorization Required:  Yes  No  
*Please fax authorization with this form*

In order to facilitate your patient's evaluation process, please use this section as a checklist to provide the following records.

History and Physical	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	
Most Recent Office Notes	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	
Current Medication List	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	
Diagnostic Tests	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	
Completed Referral Form	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	
Copy of Insurance Card (Front & Back)	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	
Copy of Driver's License	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	
Your office address, fax & phone numbers	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	

Completed by: _____	Phone: _____
Address: _____	Fax: _____

Once we receive all referral patient information requested on this form, the patient will typically be seen within 2-6 weeks. We will also notify the patient regarding appointment date/time, test results, treatment, diagnostic information. We will provide visit notes to your office using the contact information provided above.

**For ETC Purposes Only**

Received by: \_\_\_\_\_ Date: \_\_\_\_\_