



5002 Cowhorn Creek Drive  
 Texarkana, Tx. 75503  
 Phone: (903) 614-3001  
 Fax: (903) 614-3519

### CARDIOLOGY

CONSULT (Request for advice / opinion) or  REFERRAL (Request for management of care)  
 (Please only select one request)

#### REQUESTING PROVIDER INFORMATION

Requesting Provider Name Requesting Provider Address (street, city, state, zip)

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Requesting Provider Telephone Requesting Provider Fax Number NPI #

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#### APPOINTMENT REQUEST

#### DIAGNOSIS

<input type="checkbox"/> <b>John Strayhorn, MD</b>	
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\*\*\*\*\* DOCUMENTATION \*\*\*\*\*

*Please provide consulting physician with all applicable CLINIC NOTES, HISTORY & PHYSICAL, PREVIOUS PROCEDURES, LABORATORY RESULTS, PATHOLOGY REPORTS, RADIOLOGY REPORTS, AND OPERATIVE REPORTS pertinent to the patients visit. Please fax all documentation to (903) 614-3519. Thank you in advance for the request and your cooperation.*

#### PATIENT and INSURANCE INFORMATION

Patient Name (First, Middle Initial, Last) Gender

	<input type="checkbox"/> Male <input type="checkbox"/> Female
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Address City, State, Zip

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Date of Birth (mm/dd/yyyy) Social Security #

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Home Telephone Mobile Telephone Work Telephone

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Does patient need an interpreter? If yes, what language?

<input type="checkbox"/> Y <input type="checkbox"/> N	
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Does the patient have medical insurance? Name of Insurance Company and Plan Number and Group Number

<input type="checkbox"/> Y <input type="checkbox"/> N	
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Patient MR #	Patient ID #
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