UPMC
VALVE CLINIC REFERRAL FORM

Complete this form and FAX to (717) 231-8568

Patient Information

Name: _____Date:_____

Home phone: _____Cell phone:_____

Date of birth: ____/____/_____ Social Security Number: _____ E-mail:_____

Address: _____

Primary Insurance:_____ Secondary Insurance: _____

Primary care physician:_____

Notes:_____

Please forward the following tests results that may have been completed outside the UPMC:

Echo: ☑ TTE/deport & disc ☑ TEE/report & disc

☑ Labs within last year
☑ Cardiac Cath (report & disc)
☑ PFTs (Spirometry and Diffusion Capacity)
☑ EKG
☑ CTA (chest/abdomen/pelvis) (report & disc)
☑ Stress Test
☑ Carotid US
☑ Most recent CardioNet or Holter Monitor

Referring Provider Information

Name: _____**Phone:** _____

Referring Fax: _____

If there are any problems with this transmittal, please call: (717) 231-8555

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Brady Building, 4th floor
205 South Front Street
Harrisburg, PA 17104
(717) 231-8555
(855) 275-6478 (BRK-NHRT)
FAX – (717) 231-8568

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