# PINNACLE HEALTH
# 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 Pinnacle Health System:**

**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**

**DISCLAIMER:**
The information contained in this facsimile message is intended for the sole confidential use of the designated recipients and may contain confidential information. If you have received this information in error, any review, dissemination, distribution or copying of this information is strictly prohibited. If you have received this communication in error, please notify us immediately by telephone and return the original message to us by mail or if electronic, reroute back to the sender. Thank you.
If you do not receive all pages, please call the sender at the above number.

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**ValveClinic@PINNACLEHEALTH.org**

PINNACLEHEALTH
CardioVascular Institute