

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
- | | |
|--|--|
| <input checked="" type="checkbox"/> Labs within last year | <input checked="" type="checkbox"/> CTA (chest/abdomen/pelvis) (report & disc) |
| <input checked="" type="checkbox"/> Cardiac Cath (report & disc) | <input checked="" type="checkbox"/> Stress Test |
| <input checked="" type="checkbox"/> PFTs (Spirometry and Diffusion Capacity) | <input checked="" type="checkbox"/> Carotid US |
| <input checked="" type="checkbox"/> EKG | <input checked="" type="checkbox"/> 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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(855) 275-6478 (BRK-NHRT)
FAX - (717) 231-8568**

**UPMC | HEART AND
VASCULAR INSTITUTE**