BLUE RIDGE
Cardiovascular Associates

PATIENT REFERRAL FORM

Zia Roshandel, M.D., F.A.C.C.

Patient Name: _____ Date of Birth: _____

Address: _____

Home Telephone: _____ Cell Phone: _____ Work Phone: _____

Insurance: _____ Member ID: _____

Ordering Physician's Name:_____ Office Telephone: _____

Date Ordered: _____ Referral/Prior Auth Number: _____ Pre-cert? O Yes O No

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Appointment Date: _____ O Mon O Tue O Wed O Thu O Fri Time: _____ am/pm

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Nuclear Cardiology

Dx: _____

Ht: _____ Wt: _____

O Exercise Nuclear Stress Test

O Pharmacologic Nuclear Stress Test

Echocardigraphy

Dx: _____

Ht: _____ Wt: _____

O Echocardiogram

O Exercise Stress Echo

O Pharmacologic Stress Echo

O Transesophageal Echo (TEE)

Vascular Testing

Dx: _____

Ht: _____ Wt: _____

O Carotid Doppler

Non-Imaging Studies

Dx: _____

Ht: _____ Wt: _____

O Treadmill Exercise Stress Test

O ECG (Electrocardiogram)

O Holter Monitor:

- O 24 Hour
- O 48 Hour

O Event Monitor

O Cardionet Monitor

O Tilt Table

O Cardioversion

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