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Physician Referral Order Form

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Cumming Office

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Suite 2500
Cumming, GA 30041

Phone: 678-679-6800
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All insurances are accepted.

Please send a completed referral order form with copies of lab work, EKG, prior cardiac diagnostic results, etc.

PATIENT INFORMATION

Patient Name: _____ DOB: ____/____/____ Phone: _____

DIAGNOSTIC

INDICATIONS

Nuclear Exercise Thallium: _____

Nuclear Chemical Stress Thallium: _____

Exercise Treadmill Test: _____

Exercise Stress Echocardiogram: _____

Chemical Stress Echocardiogram: _____

Echocardiogram: _____

General Ultrasound:

Right Upper Quadrant: _____ Abdomen: _____

Renal: _____ Thyroid: _____

ABI / Lower Extremity

Arterial Duplex: _____

Lower Extremity

Venous Duplex: _____

Carotid: _____

Abdominal Aortic

Aneurysm Duplex: _____

Renal Artery Duplex: _____

Signature of Referring Physician: _____

Print Name: _____ Phone: _____ Date: ____/____/____

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