Cardiology Referral Form

Blanchard Valley Medical Associates, Inc.

Dr. Gregory Gerschutz (419) 427-1581

Dr. David Meier (419) 427-1594

Date of Referral: ______/______/______

Referring Physician Name: ____

Referring Physician Phone: ___________________ Referring Physician Fax: ____________________

Referring To: ❒ Dr. Gregory Gerschutz ❒ Dr. David Meier ❒ No Preference

Patient Demographic Information

Patient Last Name: __________________________________

Patient First Name: __________________________________ Patient Middle Initial: ________

Patient Date of Birth: ______/______/______

Patient Address: ____

Patient City: _____________________________ Patient State: __________ Patient Zip: ____________

Patient Phone: (*Please mark an X to indicate the preferred contact number.)*

❒ Home: __________________ ❒ Cell: __________________ ❒ Work: __________________

Clinical Information

Reason for Cardiology Consultation (Diagnosis): ____________________________________

Does the patient have a pacemaker / ICD? ❒ Yes ❒No (If yes, **attach last device check report**.)

Does the patient have a previous cardiologist? ❒ Yes ❒No (If yes, **attach records.**)

Please send the following required attachments with this Referral Form:

- ⇒ EKG / report (done within last 30 days)
- ⇒ Recent laboratory results
- ⇒ Any previous reports related to:
  - ⇒ Holter monitoring
  - ⇒ Echocardiography
  - ⇒ Stress Testing
  - ⇒ Heart Catheterizations
  - ⇒ Other: ____
- ⇒ Office / progress notes related to cardiac diagnoses
- ⇒ Copy of insurance card(s) - Include front and back of primary and secondary (if applicable)

Fax completed form and required attachments to:
(419) 427-1780

PLEASE HAVE PATIENT CALL OUR OFFICE TO SCHEDULE

*****IF REFERRAL IS URGENT, REFERRING PHYSICIAN OFFICE SHOULD CALL TO SCHEDULE*****