Lexington Heart Specialists, PSC

Consultation Request

William H. Skinner MD, FACC Michael G. Rukavina MD, FACC

Please fax form and records to (859) 278-0321. If the patient needs diagnostic testing or an outpatient procedure in addition to the consult, please contact our office for further instructions at (859) 278-0383.

DATE OF REQUEST: ______________________

PATIENT NAME: ____ **DOB:** ____________________

DIAGNOSIS/REASON FOR REFERRAL: ____

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REFERRING PROVIDER: ____

REFERRING PHONE: ____________________________ **REFERRING FAX:** ____________________________

Please return this form with the following records:

- ○ Patient Demographics *(required)*
- ○ Insurance Cards *(required)*
- ○ Office Note
- ○ EKG

Referral Urgency:

- ○ 48 hours
- ○ 5 days
- ○ 14 days
- ○ First Available

* For LHS Staff Only *

Request Received: __________________________ LHS Employee: ___________________________

Confirmed with patient: ______________________ REF Office notified: _______________________

Appointment date/time: ____

○ Unable to Contact – Referral will be filed in the patient's chart. Please have him/her call us to schedule an appt.

Comments: ____