

Physician Referral Form

Abo-Auda Associates Cardiovascular Services

Phone: (214) 592-8188 | FAX: (915) 206-2822

PATIENT INFORMATION:

Patient Name

Date of Birth:

Phone Number

SYMPTOMS: (Check all that apply)

Chest Pain	Shortness of Breath	Palpitations
Fatigue/Weakness	Fainting	Dizziness
Leg Swelling	Leg Pain	Arm Pain
Abnormal EKG	High BP	High Cholesterol

REQUESTED SERVICES: (Check all that apply)

Consultation	EKG	Echocardiogram
Stress ETT	Stress Echo	Stress Nuclear
Carotid Duplex	Peripheral Duplex	Venous Duplex
ABI	Holter Monitor	30-Day Monitor

REFERRING PHYSICIAN INFORMATION:

Name:

Phone Number

FAX Number