



2134 Hampton Place, Okemos, MI 48864
Phone (517) 347-3000
Fax (517) 347-8393



1500 S. Main St, Eaton Rapids, MI 48227
Phone (517) 663-9403
Fax (517) 663-8615

IBRAHIM SHAH, M.D.

Request for Consultation/Procedure

Please fax this form back to (517) 663-8615

Referring Physician: _____
Physician's full name

Phone: _____
Fax: _____

Physician Signature: _____

Date: _____

Patient Name: _____ <input type="checkbox"/> New Pt. <input type="checkbox"/> Prev. Pt.		
_____ <i>Last</i>	_____ <i>First</i>	_____ <i>Middle</i>
Address: _____		Home Phone: _____
City: _____	DOB: _____	Work Phone: _____
Zip Code: _____	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Cell Phone: _____

Insurance Type: ☐ Aetna ☐ BCBSM ☐ BCN ☐ Blue Preferred Plus ☐ Cofinity ☐ McLaren Health Plan
☐ Medicaid ☐ Medicare (Circle – Advantage / BCN / Plus Blue) ☐ McLaren ☐ PHP ☐ Other _____
Contract # _____ Group # _____ Copay \$ _____
Subscriber Name: _____ DOB: _____ Relationship to Patient: _____

REASON FOR REFERRAL

- | | |
|---|---|
| <input type="checkbox"/> Arrhythmia | <input type="checkbox"/> Palpitations |
| <input type="checkbox"/> Chest Pain / Angina | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Syncope |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Surgical Clearance (Date of Surgery _____) |
| <input type="checkbox"/> Other _____ | Surgery Type _____ Surgeon _____ |

TYPE OF REFERRAL REQUESTED

- ☐ Consult
☐ Consult with Cardiac Testing as Selected
☐ Test Only – Referring Physician to give test results to patient
☐ Test Only – Include consult if test results abnormal

TESTING REQUESTED

- | | |
|--|---|
| <input type="checkbox"/> Abdomen Ultrasound | <input type="checkbox"/> Stress Cardioltite w Treadmill (Pt Weight: _____ lbs) |
| <input type="checkbox"/> Carotid Doppler | <input type="checkbox"/> Stress Cardioltite w Persantine (Pt Weight: _____ lbs) |
| <input type="checkbox"/> Echocardiogram | <input type="checkbox"/> Stress Cardioltite w Lexiscan (Pt Weight: _____ lbs) |
| <input type="checkbox"/> Event Recorder (30-day) | <input type="checkbox"/> Stress Echo w Treadmill (Pt may exercise) |
| <input type="checkbox"/> Holter Monitor (24-hour) | <input type="checkbox"/> Stress Echo w Lexiscan (Pt may NOT exercise) |
| <input type="checkbox"/> Arterial Doppler R / L Upper / Lower | <input type="checkbox"/> Stress Test w Treadmill (no imaging) |
| <input type="checkbox"/> Venous Doppler R / L Upper / Lower | |

OFFICE USE ONLY

Appointment Date: _____ Time: _____ Patient Notified (date/time): _____ By: _____
Referring Physician's Office Notified (date/time): _____ By: _____