McLaren
CARDIOVASCULAR GROUP

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

# Request for Consultation/Procedure

**Please fax this form back to MCG**

**Referring Physician:** _____ **Phone:** _____
*Physician's full name*
**Fax:** _____

**Physician Signature:** _____ **Date:** _____

**Appointment Priority:** ***Please call for same day appointments.***

☐ Expedited (within 72 hours) ☐ Routine (1-2 weeks) ☐ Patient's convenience

**Patient Name:** _____ ☐ New Pt. ☐ Prev. Pt.
*Last* *First* *Middle*

**Address:** _____ **Home Phone:** _____

**City:** _____ **DOB:** _____ **Work Phone:** _____

**Zip Code:** _____ **Sex:** ☐ Male ☐ 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

☐ Arrhythmia
☐ Chest Pain / Angina
☐ Congestive Heart Failure
☐ Heart Murmur
☐ Other _____
☐ Palpitations
☐ Shortness of Breath
☐ Syncope
☐ Surgical Clearance (Date of Surgery _____)
Surgery Type_____ Surgeon_____

## TYPE OF REFERRAL REQUESTED

☐ Consult
☐ Consult with Cardiac Testing as Selected
☐ Cardiac Test Only – Referring Physician to give test results to patient
☐ Cardiac Testing with Consult if test results abnormal
☐ Cardiac Testing – ICG physician to determine appropriate test

## TESTING REQUESTED

☐ Abdomen Ultrasound
☐ Ankle-Brachial Index for PAD screening
☐ Carotid Doppler
☐ Echocardiogram
☐ Event Recorder (30-day)
☐ Holter Monitor (24-hour)
☐ Arterial Doppler **R / L Upper / Lower**
☐ Venous Doppler **R / L Upper / Lower**
☐ Stress Cardiolite w Treadmill (Pt Weight: _____ lbs)*
☐ Stress Cardiolite w Persantine (Pt Weight: _____ lbs)*
☐ Stress Cardiolite w Lexiscan (Pt Weight: _____ lbs)*
☐ Stress Echo w Treadmill (Pt may exercise)
☐ Stress Echo w Lexiscan (Pt may NOT exercise)
☐ Stress Test w Treadmill (no imaging)
***Please provide pre-authorization for any Nuclear testing***

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