Physician Referral Form **Phone: 423-498-3300 Fax: 423-498-3301**

Patient Information (Please Print)

Last Name	First Name & MI	Age	Date of Birth	M/F

Street Address	City	State	Zip Code

Translator Needed? Yes No **Language:**

Parent/Guardian Name	Home #	Work#	Cell #

Insurance Plan	Policy #	Group #	Policy Holder Name and Date of Birth

Referring Physician Information

Referring Physician Name	Name of Practice	
Practice Contact	**Office Phone**	**Office Fax**

Referring Issue: PLEASE include demographics, clinic summary and H & P. Fax to 423-498-3301

___Syncope	Number of syncopal episodes?_____ Dizzy Spells?_____ Associate with Exercise? **Y** **N** Any other symptoms? **Y** **N** If yes, what?
___Murmur	Good femoral pulse? **Y** **N** Is the child tachypneic? **Y** **N** Is there Cyanosis? **Y** **N** Any signs of CHF? **Y** **N** Any other symptoms? **Y** **N** If yes, what?
___Palpitations	How often do palpitations occur? How long do they last? Any documented heart rates? **Y** **N** If yes what? Any associated with syncope? **Y** **N** Any documented SVT? **Y** **N**
___Chest Pain	Associated with exercise? **Y** **N** Any associated with syncope? **Y** **N** Any other symptoms? **Y** **N** If yes, what?
___Abnormal ECG	Why was the ECG ordered? What are you concerned with? Any other symptoms? **Y** **N** If yes, what?
___Abnormal Echo	Why was the echo ordered? What are you concerned with? Any other symptoms? **Y** **N** If yes, what?
___Genetic Disorder	What genetic disorder does the patient have?
___Other	List concerns:
Physical exam:	Normal **Y** **N** If no, what is abnormal?
Family History:	Sudden Cardiac Death? **Y** **N** If yes, who? At what age? Cardiomyopathy? **Y** **N** If yes, who? At what age? Long QT syndrome? **Y** **N** If yes, who? At what age?
Prior test performed	ECG _____ Echo _____ CXR_____ Holter_____ **(PLEASE include ALL reports with refferal)**