

# PROVIDER REFERRAL FORM

2711 Randolph Road, Suite 305 Phone: 704-334-0600  
Charlotte, NC 28207 Fax: 704-334-0615

**Aamer A. Qureshi, M.D., FACC, FSCAI**  
**Stephanie J. Baumann, PA-C**



Board Certified in Diagnostic and Invasive Cardiology

**Referring Provider Information:**

Provider Name: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Referral Coordinator: \_\_\_\_\_ Fax #: \_\_\_\_\_  
Patient Diagnosis/ICD Code: \_\_\_\_\_

Urgency of Appointment:  Routine  ASAP  Urgent

Medical records faxed with this referral?  Yes  No

*\*\*Please fax the following records for new patients: Last 2 office notes, recent labs, medication list, EKGs, and any cardiac test results\*\**

**Patient Information:**

Name: \_\_\_\_\_ Sex:  M  F DOB: \_\_\_\_\_  
Address: \_\_\_\_\_  
Home #: \_\_\_\_\_ Work #: \_\_\_\_\_ Cell #: \_\_\_\_\_  
Insurance: \_\_\_\_\_ I.D #: \_\_\_\_\_ Group #: \_\_\_\_\_

## How May We Assist You?

**MD Visit:**

Consultation  
 Pre-Operative clearance  
Date of Surgery: \_\_\_\_\_  
*\*Leave blank if unknown\**  
Type of Surgery: \_\_\_\_\_

**In-Office Procedures:**

Venous Ablation  
 Arteriography  
 Implantable Loop Recorder

**Echocardiography:**

2D Echocardiogram  
 Transesophageal Echocardiogram  
 Stress Echocardiogram

**Vascular Ultrasound:**

Renal Duplex  Carotid Duplex  
 Abdominal Aorta Duplex  
 Lower Extremity Arterial Duplex  
 Lower Extremity Venous Duplex  
 Vein Mapping

**Out-of-Office Procedures:**

Cardioversion  
 Tilt Table  
 Left Heart Cath  
 Right Heart Cath  
 Pacemaker Implant

**Stress Testing:**

Nuclear Stress Test  
 Treadmill Only

**Cardiac Rhythm Monitoring:**

24-hour holter monitor  
 3-14 day holter monitor  
 30 day event monitor

**Provider Referral Confirmation**

Referral Accepted? Yes / No Explain: \_\_\_\_\_  
Appointment scheduled: \_\_\_\_\_ Time: \_\_\_\_\_  
\_\_ Patient Notified on \_\_\_/\_\_\_/\_\_\_  
\_\_ New Patient Packet Mailed / Emailed