Elite Cardiovascular Group
Dr. Nalluri & Dr. Asti

Physician Referral Form

Patient Name: _____ Patient DOB: _____

Patient Home Phone #: _____ Patient Cell Phone #: _____

Primary Insurance: _____ ID #: _____ Insurance Phone #: _____

Referring Physician Name: _____ Referring Physician Phone #: _____

Indication for Referral: _____

_____

Below is a list of referral indications, please place a checkmark next to all indications that apply to the referral request

- ☐ Echocardiogram
- ☐ Stress Echocardiogram
- ☐ Ambulatory Rhythm Monitoring (Holter & Event Monitor)
- ☐ Stress Test
- ☐ Nuclear Cardiac Stress Test
- ☐ Arterial Brachial Index (ABI)
- ☐ Arterial Duplex Scan (Holter & Event Monitor)
- ☐ Venous Duplex Scan
- ☐ Carotid Duplex Scan
- ☐ Cardiac Rhythm Management
- ☐ Electrocardiogram
- ☐ General Cardiology Consultation
- ☐ Heart Failure Consultation
- ☐ Pre-Operation Clearance
- ☐ Cardiac & Vascular Screening
- ☐ Pacemaker/Defibrillator Interrogation
- ☐ Chest Pain
- ☐ Leg Pain/Ulcer/ Vascular Disease
- ☐ Varicose Veins/ Venous Insufficiency
- ☐ Lower Extremity Swelling
- ☐ Abnormal Electrocardiogram
- ☐ Heart Murmur
- ☐ Heart Valve Disorders

If necessary please further specify the reason for the referral: _____

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Please include the referring doctor note, any important testing, or documentation pertinent to this request.
Please fax the completed form to: 972-572-2133

Main Office: 925 York Dr, Desoto TX 75115 **Phone: 972-572-1600 Fax: 972-572-2133**