22474-45

Children's Healthcare of Atlanta Heart Center

PULMONARY HYPERTENSION CLINIC REFERRAL FORM

Name________________________________

Date of Birth________________________________

MRN#________________________________

Account/HAR#________________________________

PATIENT IDENTIFICATION

Date: ____________________

Patient Name: ____ DOB: ________________ Age: ________________

Patient's Name: ____ Home Phone: ____________________________

Home Address: ____ Cell Phone: ____________________________

____ Work Phone: ____________________________

Referring Physician: ____________________________________ Contact Number: __________________________

Primary Care Physician: _________________________________ Office Phone: ____________________________

Reason for Referral: ____

____

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Diagnosis(es): ____

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Person Completing Form (print): ____

Signature: ____ Date: ________ Time: ________

INSTRUCTIONS: please include (as applicable):

- ☐ Demographics sheet (including insurance information)
- ☐ Most recent clinic note
- ☐ Cardiac catheterization report (if relevant)
- ☐ Echocardiogram report (if relevant)
- ☐ Other imaging/clinical information (if relevant)

Call the PH program office directly at 404-785-2950 with questions.

Please fax this form and above documents to 404-785-1869 Total number of pages: _________ (Inclusive)

Visit choa.org/ph for more information

Not Part of the Patient Medical Record.
Return to the Heart Center department.