



Children's Healthcare of Atlanta Cardiology Referral Form

Phone: 404-256-2593 or 800-542-2233
www.choa.org/heart

Please fax signed form to **404-252-7431**.

Authorization Number _____ (if needed)

Patient Name: _____ **Date of Birth:** ___/___/___ **Patient Phone:** _____

Referring Provider Name: _____ Provider Phone: _____ Provider Fax _____

(PLEASE PRINT)

Electronic Referral Options

(EPIC or accessCHOA access required - no fax needed)

Option 1: Evaluate and Treat

Cardiology Referral - 99002070MO

*accessCHOA users can attach records to the electronic order



Option 2: Test Only

___ EKG Order - 22000001MO CHR EKG – Children's Cardiology Clinic

___ Echocardiogram Order - 99002151 CHR ECHOCARDIOGRAM –
Children's Cardiology Clinic

Option 1: Evaluate and Treat

**Fax demographic sheet, clinical notes or other records needed
for the appointment, with referral to 404-252-7431**

Diagnosis: (Check all that apply for full evaluation by Cardiologist)

- | | |
|-----------------------------|---|
| ___ Chest pain | ___ Cyanotic Episodes |
| ___ Syncope/lightheadedness | For DX below, send information as indicated: |
| ___ Palpitations | ___ Hypertension (Send prior BP readings) |
| ___ Tachycardia | ___ Hyperlipidemia (Send most recent labs) |
| ___ Cardiac Clearance | ___ Abnormal ECG (Send previous ECG) |
| ___ Murmur | ___ Other _____ |

Option 2: Test Only

**Orders must be received before a test can be performed:
Fax this order to 404-252-7431.**

Patient will NOT see a Cardiologist

Diagnosis _____

Reason for Study _____

- ___ ECG (Need previous ECG if available)
- ___ Echocardiogram
- ___ Extended ECG Rhythm Patch - (0-48 hours)
- ___ Extended ECG Rhythm Patch - (3 days-7 days)
- ___ Extended ECG Rhythm Patch - (8 days-14 days)

Children's Cardiology

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➔ Referring Provider Signature Required: _____ **Date:** ___/___/___

Call us to schedule appointment at 404-256-2593

To request more pads to be sent to your office, visit choa.org/orderpad