Hypertension Clinic

Physician referral form

Thank you for referring your patient for an evaluation. In order to expedite the referral, please fax the following information along with this completed referral form to **404-785-6586**.

- Clinic notes pertaining to the reason for referral
- 5 or more elevated blood pressure readings
- All lab and radiologic results (including ECHO) related to the reason for referral

Once the information is received, the chart will be reviewed and the patient will be offered an appointment. For optimal patient care, it is important that all pertinent clinical and diagnostic records are faxed at the time of referral. This avoids unnecessary repetition of testing and allows us to give the family a more complete analysis of the child's problem. We appreciate your assistance in optimizing your patient's care.

_____
Referring physician's name

_____
Practice name

_____
Date of referral

_____
Phone

_____
Fax

_____
Physician's email

_____
Contact person's name

_____
Contact person's phone

FOR OFFICE USE ONLY

Children's response to referral.

☐ Appointment scheduled

Date: _____

Time: _____

_____
Provider's name

☐ Unable to contact patient

Patient's name: _____

Patient's date of birth: _____ ☐ Male ☐ Female

Parent/guardian's name: _____

Home address: _____

Home phone: _____ Work phone: _____

Cell phone: _____

PRIMARY INSURANCE

Is a referral required to see a specialist? ☐ Yes ☐ No

If "yes", please attach a referral/referral number with this form.

Primary insurance: _____

☐ HMO ☐ PPO ☐ POS ☐ Other: _____

ID number: _____ Group number: _____

Guarantor's name: _____ DOB: _____

Provider/customer service phone number for benefits: _____

SECONDARY INSURANCE

Is a referral required to see a specialist? ☐ Yes ☐ No

If "yes", please attach a referral/referral number with this form.

Primary insurance: _____

☐ HMO ☐ PPO ☐ POS ☐ Other: _____

ID number: _____ Group number: _____

Guarantor's name: _____ DOB: _____

Provider/customer service phone number for benefits: _____