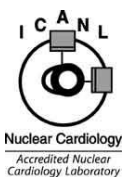




Cardiology Associates of Fredericksburg, Ltd.

APPOINTMENT REQUEST

Preferred Practitioner (if applicable) <input type="checkbox"/> FIRST AVAILABLE		
<input type="checkbox"/> Richard A. Lewis, M.D., F.A.C.C.	<input type="checkbox"/> Scott J. Seidner, M.D., F.A.C.C.	<input type="checkbox"/> Christine Leitz, PA-C
<input type="checkbox"/> Frank R. Snow, M.D., F.A.C.C.	<input type="checkbox"/> Patrick J. Fitzsimmons II, M.D.	<input type="checkbox"/> Christine Howell, M.S.N., A.C.N.P.
<input type="checkbox"/> Gregory J. Kauffman, M.D., F.A.C.C.	<input type="checkbox"/> Anh D. Vu, M.D.	<input type="checkbox"/> Anne Pingrey, M.S.N., A.N.P.
Requested Services	Visit www.fredcardio.com for more information about physicians and services.	
<input type="checkbox"/> Consult	<input type="checkbox"/> Routine Exercise Stress Test	<input type="checkbox"/> Echocardiogram
<input type="checkbox"/> Pre-op Clearance	<input type="checkbox"/> Exercise Nuclear Stress Test	<input type="checkbox"/> Saline Contrast Echocardiogram
<input type="checkbox"/> Electrocardiogram (EKG)	<input type="checkbox"/> Pharmacologic Nuclear Stress Test	<input type="checkbox"/> Transesophageal Echocardiogram
<input type="checkbox"/> Holter Monitor (24-hour)	Severe lung disease? – YES / NO	<input type="checkbox"/> Carotid Duplex
<input type="checkbox"/> Arrhythmia Monitor (30-day)	<input type="checkbox"/> Stress Echocardiogram	<input type="checkbox"/> Ankle-Brachial Index (ABI)
<input type="checkbox"/> Tilt Table Test	<input type="checkbox"/> Dobutamine Stress Echocardiogram	<input type="checkbox"/> Exercise Ankle-Brachial Index
<input type="checkbox"/> FOLLOW-UP CONSULT IF TEST RESULTS ARE ABNORMAL		
Referring Office Information		
Ordering Physician _____	Urgency of Request _____	
Office Contact _____	Phone _____	Fax _____
Patient Information		
Name (Last, First MI) _____	SSN _____ / _____ / _____	
DOB _____ / _____ / _____	Sex M / F	Diabetic YES / NO
Weight _____		
Address _____	City _____	State _____ Zip _____
Home Phone _____	Work Phone _____	Cell Phone _____
Primary Insurance _____	Policy# _____	Group# _____
Secondary Insurance _____	Policy# _____	Group# _____
INCLUDE COPY OF FRONT AND BACK OF INSURANCE CARDS		
Referral/Authorization # _____		
DIAGNOSIS _____	Date of onset _____	
MEDICATIONS _____		
SPECIAL NEEDS (i.e. deaf, wheelchair, etc.) _____	OFFICE USE ONLY	
PLEASE FAX COMPLETED FORM TO 540-373-1124 INCLUDE CURRENT EKG, LAST OFFICE NOTE AND RECENT LABS IF AVAILABLE Our office will notify you when the appointment has been schedule.		_____ _____ _____



Massaponax Medical Park • 9530 Cosner Drive, Suite 200 • Fredericksburg, Virginia 22408
 (540) 373-1331 • Fax (540) 373-1124

