



Cardiology Associates of Fredericksburg, Ltd.

APPOINTMENT REQUEST

Preferred Practitioner (if applicable) <input type="checkbox"/> FIRST AVAILABLE		
<u>General Cardiology</u> <input type="checkbox"/> Frank R. Snow, M.D., F.A.C.C. <input type="checkbox"/> Gregory J. Kauffman, M.D., F.A.C.C. <input type="checkbox"/> Anh D. Vu, M.D. <input type="checkbox"/> Anita Banerjee, M.D., F.A.C.C.	<u>Interventional Cardiology</u> <input type="checkbox"/> Scott J. Seidner, M.D., F.A.C.C. <input type="checkbox"/> Zeshan A. Rana, M.D., F.A.C.C. <input type="checkbox"/> Rajiv Tayal, M.D., F.A.C.C. Visit www.fredcardio.com for more information about physicians and services.	<u>Electrophysiology</u> <input type="checkbox"/> Ashok Talreja, M.D., F.A.C.C., F.H.R.S.
Requested Services <input type="checkbox"/> FOLLOW-UP CONSULT IF TEST RESULTS ARE ABNORMAL		
<input type="checkbox"/> Consult <input type="checkbox"/> Pre-op Clearance <input type="checkbox"/> Electrocardiogram (EKG) <input type="checkbox"/> Holter Monitor (24-hour/48-hour) <input type="checkbox"/> Arrhythmia Monitor (30-day) <input type="checkbox"/> Carotid Duplex	<input type="checkbox"/> Routine Exercise Stress Test (GXT) <input type="checkbox"/> Exercise Nuclear Stress Test (NGXT) <input type="checkbox"/> Pharmacologic Nuclear Stress Test Severe lung disease? – YES / NO <input type="checkbox"/> Stress Echocardiogram	<input type="checkbox"/> Echocardiogram (TTE) <input type="checkbox"/> Saline Contrast Echocardiogram <u>Hospital Outpatient Procedures</u> <input type="checkbox"/> Tilt Table Test <input type="checkbox"/> Transesophageal Echocardiogram (TEE)
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
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 (540) 373-1331 • Fax (540) 373-1124 • www.fredcardio.com

