

-Referral Form-

Today's Date: _____ Patient Name: _____

Patient DOB: _____ Patient Phone Number: _____

Patient Current Diagnosis: _____

Patient Insurance Name: _____

Patient Insurance Member ID Number: _____

Name of Referring Provider: _____

For a Consult Referral, please select from the following HEART Physicians. (please circle one or first available):

Dr. Nima Amjadi, M.D.

Dr. Brian Allen, M.D.

First Available

For an Outpatient Service Only Referral, please provide the following and select from the services below:

(Required) Patient Current Qualifying Diagnosis:

CPT Code: _____

Echocardiography

Stress Testing

○ Chemical*

▪ PET Nuclear*

▪ SPECT Nuclear*

○ Treadmill*

▪ Echo*

▪ SPECT Nuclear*

○ Plain Treadmill

Ankle-Brachial Index (ABI)

Holter Monitoring Devices

Mobile Continuous Telemetry

Implantable Loop Recorder*

Abdominal Aortic Ultrasound

Venous Studies

Arterial Dopplers

At Home Sleep Studies

Comments: _____

Please fax or email patient demographics, medical records, and insurance cards to **Fax # 512-215-8824** or **email referrals@heartdoc.care** and include this form as the cover sheet. You can also process a referral through www.leadingreach.com. **For Outpatient Services Only, please note that on the referral.**

Heart Endovascular and Rhythm of Texas – H.E.A.R.T.

www.heartdoc.care

Dr. Nima Amjadi & Dr. Brian Allen

South Austin
4310 James Casey, Bldg 1, Suite A
Austin, TX 78745



Dripping Springs
170 Benney Lane, Suite 100
Dripping Springs, TX 78620

*Items with a * require a consult referral due to the requirement for HEART to obtain a prior authorization*