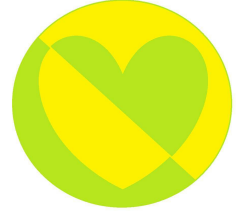


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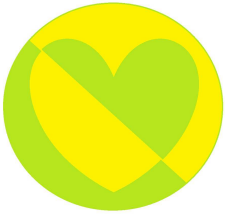
Kansas City Pediatric Cardiology Associates
Referral Form Instructions

Please send the following items:

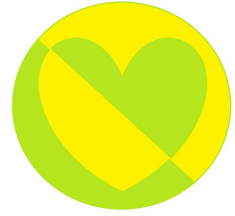
- 1. A copy of the front and back of the patient's insurance card.**
- 2. To help us take care of your patient, we would appreciate copies of the following documents (if available):**
 - a. Last progress note or encounter note**
 - b. Complete medication list**
 - c. ECG, Holter monitor and echocardiogram reports**
 - d. Patient face sheet or demographics**

Thank you very much for the referral! Please contact us at: (816) 584-0505 if you have any questions!

Stacy, Cheryl, Vickie and Dr. Bill Drake
The folks at KC Pediatric Cardiology



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Kansas City Pediatric Cardiology Associates
Referral Form

Provider:

Phone:

Fax:

<u>Patient Name</u> Last:	First:	MI:
<u>Patient date of birth:</u>		
Insurance:	ID#	

Reason for referral (mark all that apply):

<input type="checkbox"/> Murmur	<input type="checkbox"/> Sports clearance	<input type="checkbox"/> Abnormal ECG
<input type="checkbox"/> Chest pain	<input type="checkbox"/> Fast/irregular/slow heart rate	<input type="checkbox"/> <u>ADHD meds ECG ONLY</u>
<input type="checkbox"/> Palpitations	<input type="checkbox"/> Syncope/near syncope	<input type="checkbox"/> ECG Only (Reason):
<input type="checkbox"/> Short of breath	<input type="checkbox"/> History of Cong Heart Dz	_____
<input type="checkbox"/> Family history of _____	<input type="checkbox"/> Other _____	_____

Contact information (please complete!)

Contact name: _____ Relation to patient: _____

Contact phone: _____

Home phone
Cell phone (check one)
Work phone

Contact email: _____

Please fax to: 816 265-6333
or
email to: admin@kckidheart.com

Additional practice information:
Phone: 816 584-0505
Website: www.KCKidHeart.com

Address: 4150 N. Mulberry Suite 150
Kansas City, MO 64116