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Kansas City Pediatric Cardiology Associates
Referral Form

Referring Provider: _____ Phone: _____ Fax: _____

Patient Name Last: _____ First: _____ **DOB**: _____

Insurance Co: _____ ID# _____

Subscriber Name: _____ Subscriber DOB: _____

Reason for referral:

- ☐ Murmur
- ☐ Chest pain
- ☐ Palpitations
- ☐ Short of breath
- ☐ Sports clearance
- ☐ Fast/irregular/slow heart rate
- ☐ Syncope/near syncope
- ☐ History of Cong Heart Dz
- ☐ Previous Abnormal EKG
- ☐ Family history of:

EKG ONLY: *use this area if the provider is ordering ONLY an EKG*

Reason for EKG: _____

Contact information (please complete!)

Contact name: _____ Relation to patient: _____

Phone: _____ Alt phone: _____

Contact name: _____ Relation to patient: _____

Phone: _____ Alt phone: _____

Please include with this referral form:

1) patient face sheet or demographics form
2) copy of current insurance card
3) recent office visit note
4) any labs, ekg's, holter monitor or echocardiogram reports
5) medication list

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

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

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