WakeMed
Heart & Vascular Physicians

REQUEST FOR REFERRAL

Please visit www.wakemed.org/heart-vascular-all-providers to obtain specific information

☐ **Apex Office**
WakeMed Apex Healthplex
120 Healthplex Way, 201
Apex, NC 27502
Phone # (919) 232-0323
Fax # (919) 367-2693

☐ **Brier Creek Office**
WakeMed Brier Creek Healthplex
8001 T.W. Alexander Drive, 204
Raleigh, NC 27617
Phone # (919) 350-9640
Fax # (919) 596-1928

☐ **Cary Office**
600 New Waverly Place, 201
Cary, NC 27518
Phone # (919) 350-2580
Fax # (919) 851-4947

☐ **Clayton Office**
Spring Branch Medical Pavilion
166 Springbrooke Avenue, 205
Clayton, NC 27520
Phone # (919) 861-8939
Fax #(919) 359-3430

	J. Richard Daw, MD		Padma Hari, MD		Bhavani Balaravi, MD		Raj Fofaria, MD
	Hemant Solomon, MD		Jack Noneman, MD		J. Richard Daw, MD		Matthew White, MD
					Jimmy Locklear. MD		

☐ **Garner Office**
WakeMed Garner Healthplex
400 US Highway 70 East, 200
Garner, NC 27529
Phone # (919) 662-5001
Fax #(919) 662-5002

☐ **Heart Center Office**
WakeMed Heart Center
3000 New Bern Avenue, G100
Raleigh , NC 27610
Phone # (919) 231-6132
Fax # (919) 231-6276

☐ **North Office**
WakeMed North Physician Office Pavilion
10010 Falls of Neuse Road, 307
Raleigh, NC 27614
Phone # (919) 847-3164
Fax # (919) 847-3195

☐ **Six Forks Office**
3324 Six Forks Road
Raleigh, NC 27609
Phone # (919) 781-7772
Fax #(919) 787-6331

	J. Mark Englehardt, MD		Jordan Allem, MD		Sahar Amery, MD		J. Mark Englehardt, MD
	Willard Kennedy, MD		Jason Haag, MD		J. Mark Englehardt, MD		George Hamrick, MD
	Jack Noneman, MD		George Hamrick, MD		Brian Go, MD		Padma Hari, MD
	Siddhartha Rao, MD		Brian Go, MD		Tapan Godiwala, MD		Willard Kennedy, MD
			John Kelley, MD		Marc Silver, MD		Jack Noneman, MD
			Jimmy Locklear, MD				Siddhartha Rao, MD
			Islam Othman, MD				
			Marc Silver, MD				
			John Sinden, MD				
			Senthil Sundaram, MD				
			Francis Wood, MD				

PATIENT INFORMATION

Name:_____ DOB:_____ Female/Male

Address: _____

Phone: (H) _____ (C) _____

Referring Physician: _____ Practice Name: _____

Referring Physician Phone Number: _____ Fax: _____

DX: _____Insurance: _____ Ins. Auth & Exp. Date_____

Please fax referral form directly to the requested office.
****PLEASE SEND PATIENT OFFICE NOTE & INSURANCE CARD AT TIME OF FAX REFERRAL****
(Front & Back of Card)

Patient Name: _____ **Date of Birth:** _____

Cardiology Consultation: ___ Yes ___ No

If yes, with whom? Please circle

Jordan Allem, MD | Sahar Amery, MD | Bhavani Balaravi, MD
J. Richard Daw, MD | Raj Fofaria, MD | Brian Go, MD
Tapan Godiwala, MD | Jason Haag, MD | Padma Hari, MD
John Kelley, MD | Willard Kennedy, MD | Jimmy Locklear, MD
Jack Noneman, MD | Islam Othman, MD | Siddhartha Rao, MD
Marc Silver, MD | John Sinden, MD | Hemant Solomon, MD
Senthal Sundaram, MD | Francis Wood, MD

First Available

Vascular Consultation: __ Yes __ No

If yes, with who? Please circle

Brian Go, MD | Islam Othman, MD | Siddhartha Rao, MD
Hemant Solomon, MD

First Available

Device Consultation / Implantation: ___ Yes ___ No

If yes, with whom? Please circle

Marc Silver, MD | Hemant Solomon, MD

First Available

Electrophysiology Consultation: ___ Yes ___ No

If yes, with whom? Please circle

J. Mark Englehardt, MD | George Hamrick, MD

First Available

Interventional Consultation: ___ Yes ___ No

If yes, with whom? Please circle

Brian Go, MD | John Kelley, MD | Jimmy Locklear, MD
Jack Noneman, MD | Islam Othman, MD | Siddhartha Rao, MD
John Sinden, MD | Francis Wood, MD

First Available

How soon do you need this consultation? _____ **Days** _____ **Weeks** _____ **ASAP**

Cardiovascular Testing

****If requesting only a cardiovascular test, please send office notes, labs and any other cardiac test/procedure results. Please obtain authorization for tests if insurance will allow. Please provide authorization information when requesting any testing to be performed.**

☐ **Pre-Authorization Obtained**
☐ **Clinic Notes Attached**
☐ **Copy of Medical Insurance Card Attached**

Nuclear Imaging:

___Treadmill Cardiolite ___MUGA Scan
___Lexiscan Cardiolite ___Dobutamine Cardiolite

Echocardiography:

___Echocardiogram (TTE) ___Stress Echocardiogram
___Bubble Study ___Transeophageal (TEE)
___Echocardiogram Limited (TTE)

If requesting nuclear imaging, please provide the following information:
Weight _____ **BP** _____ **Diabetes Y/N** **Smoker Y/N**

Vascular Imaging:

___ABI / TBI ___ ABI with Exercise
___Abdominal Aortic Duplex ___Bilateral Carotid
___Lower Extremity Arterial w/ABI (___Right___Left___Bilateral)
___Lower Extremity Venous (___Right___Left___Bilateral)
___Renal Artery Duplex
___Upper Extremity Arterial (___Right___Left___Bilateral)
___Upper Extremity Venous (___Right___Left___Bilateral)
___ Venous Insufficiency /Reflux

Other:

___24 Hour (only) Holter Monitor ___48 Hour (only) Holter Monitor
___14 Day Event Monitor ___30 Day Event Monitor
___EKG ___Exercise Treadmill Test

Radiological Ultrasound (Six Forks Office ONLY):

___ Complete Upper Abdominal Survey (GB, biliary, liver, spleen, pancreas)
___ Retroperitoneal ___ Thyroid ____ Pelvic
___ Testicular

If requesting a test, please sign below:

Physician Signature: _____ **Date:** _____