WakeMed Raleigh Campus – Heart Center
3000 New Bern Avenue, Suite 1140
Raleigh, NC 27610
Office phone: 919-350-AFIB (2342)
Fax: 919-350 9836

WakeMed
Heart & Vascular
ATRIAL FIBRILLATION CENTER

REQUEST FOR REFERRAL

PATIENT DEMOGRAPHIC INFORMATION

Date: ______________________________

Patient Name: ______________________________ Date of Birth: ____________ Gender: ☐ M ☐ F Race: ____________

Address: ______________________________ City/State/Zip: ______________________________

Phone *(Please circle preferred number)* Home: ________________ Cell: ________________ Work: ________________

Email: ______________________________

Does patient/family need an interpreter? ☐ No ☐ Yes If yes, please specify language ______________________________

INSURANCE INFORMATION

Insurance Name: ______________________________

Policyholder's Name (if other than patient): ______________________________

Policyholder's Date of Birth (if other than patient): ________________

Insurance Phone: ________________ Policy Number: ________________ Group Number: ________________

Medicaid Authorization NPI: ________________ Authorized Number of Visits: ________________

REFERRAL INFORMATION

Reason for Referral: ______________________________

____

Pertinent History: ______________________________

____

Symptoms: ______________________________

____

REFERRING PHYSICIAN INFORMATION

Name: ______________________________

Practice Name (if applicable): ______________________________

Address: ______________________________

City/State/Zip: ______________________________

Office Phone: ________________ Fax: ________________

Name of Person completing this form and phone number: ________________

____

Please include with referral (all that are applicable)

☐ History/Office Notes

☐ Labs

☐ Imaging Studies (patient should bring films or CD)

☐ Other pertinent medical records

Thank you for referring your patient to WakeMed Heart & Vascular - Atrial Fibrillation Center. Please FAX this completed form to 919-350-9836.