

YHC REFERRAL

Patient's name _____

Date of birth _____ Male _____ Female _____

Referring doctor _____ Phone _____

Indication for the test/consult: _____

(It must be an approved indication – go to <http://www.yakimaheartcenter.com/> for more information.)

Alternative 1:

Indicate which test you want: 2D Echo Holter Monitor

KOH Monitor EKG/ECG

Please include updated Demographics.

Alternative 2:

_____ Consultation

Please attach a copy of your clinical notes dealing with the reason for this referral. Also include updated demographics.

****Please fax to 574-0330****