Washington Regional
Walker Heart Institute

OFFICE USE ONLY
Records Complete: ☐ YES ☐ NO
Scheduled On:_____
Provider:_____
Patient Notified: ☐ YES ☐ NO

NEW PATIENT REFERRAL FORM

Washington Regional Electrophysiology Clinic

3211 N. Northhills Blvd. / Fayetteville, AR 72703
Phone: 479.463.8740 / Fax: 479.463.8741

PATIENT INFORMATION:

Name: _____ DOB: _____/_____/_____ Social Security #: ____ - ____ - _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (_____) _____ - _____ Cell Phone: (____) _____ - _____ Work Phone: (____) _____ - _____

Emergency Contact: _____ Phone: (____) _____ - _____ Relation: _____

Insurance Name: _____ Policy Number: _____ Policy Holder Name: _____

Primary Pharmacy: _____ City: _____ State: _____ ☐ Mail Order
Secondary Pharmacy: _____ City: _____ State: _____ ☐ Mail Order

Primary Care Provider: _____ Phone: (____) _____ - _____

REFERRING PHYSICIAN INFORMATION: ☐ 1st Available ☐ Soon ☐ Urgent

Physician's Name: _____ Phone: _____ Fax:_____

Diagnosis: _____

****** REQUIRED CLINICAL DOCUMENTATION / TESTING ******

☐ Recent EKG ☐ ≥ 48hr Holter Monitor OR 30-day Event Monitor ☐ Last Office Visit Note ☐ Echocardiogram

****** REQUIRED LABS ******

☐ Comprehensive Metabolic Panel ☐ Complete Blood Count ☐ Hepatic Function Panel ☐ Thyroid Panel with TSH

***Requested* Supportive Clinical Documentation:**

☐ Nuclear Stress Test (< 3 years) ☐ Tilt Table Test ☐ Heart Catheterization (< 6 years)
☐ Stress Echocardiogram ☐ MUGA ☐ Device Implant Information

DEVICE INFORMATION (*if applicable*):

Pacemaker: Date of insertion- _____ Inserted by: _____
Type: ☐ Single ☐ Dual ☐ CRT Make: ☐ Medtronic ☐ St. Jude ☐ Boston Scientific

AICD: Date of insertion- _____ Inserted by: _____
Type: ☐ Single ☐ Dual ☐ CRT Make: ☐ Medtronic ☐ St. Jude ☐ Boston Scientific

Loop: Date of insertion- _____ Inserted by: _____