



Referral Form

Patient Name	_____	Date	_____
Date of Birth	_____	Patient Phone	_____
Clinic Name	_____	Provider Phone	_____
Ordering Provider	_____	Provider Fax	_____
Provider Signature	_____	Provider Email	_____
Clinical History / Diagnosis	_____		

Common Indications - Select All That Apply

Chest pain / ischemia

Hypertension

Dyspnea / heart failure / edema

Peripheral Arterial Disease

Arrhythmia / palpitations / syncope

Murmur / valvular disorder

Preoperative cardiac evaluation

Other _____

Services - Select All That Apply

Cardiology Consultation

Echocardiogram (Echo)

Exercise Stress Test

ECG / EKG

Holter / Patch Monitor

Ambulatory BP Monitor

Ankle-Brachial Index (ABI)

Weight Management

Other _____

Relevant Records Attached

Office note

Recent labs

ECG

Prior cardiac imaging

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