



Patient Name: _____

DOB: _____ Email: _____

Phone #: _____ Cell #: _____

Height: _____ Weight: _____

Address: _____

Insurance Carrier: _____

Policy ID#: _____ Group #: _____

Please check the box of the requested service (Specify if exercise testing is to be done on cycle/treadmill/swim flume)

- Dr. Benjamin Levine Consult w/wo Autonomic Function Test Consult and Cardiopulmonary Exercise Testing
- Cardiopulmonary Exercise Testing Only Altitude Testing
- Dr. Satyam Sarma Cardiopulmonary Exercise Testing Cardiopulmonary Exercise Test w/Right Heart Cath
- Dr. James MacNamara Cardiopulmonary Exercise Testing Cardiopulmonary Exercise Test w/Right Heart Cath
- Dr. Andrew Tomlinson Cardiopulmonary Exercise Testing
- Dr. Salman Bhai Consult Only Consult w/ Cardiopulmonary Exercise Testing and Muscle Biopsy
- Consult with Muscle Biopsy
- Dr. Alan Martin Consult Only Consult w/ Cardiopulmonary Exercise Testing and Muscle Biopsy
- Consult with Muscle Biopsy
- Shannon Grappe, APRN POTS exercise program 24-hour Ambulatory Blood Pressure Monitor Study

Referral must include the following:

- FRONT/BACK COPIES OF INSURANCE CARD
- FRONT/BACK COPIES OF IDENTIFICATION CARD
- CLINICAL DOCUMENTATION SUPPORTING REFERRAL AND REQUESTED TESTING
- PERTINENT LAB RESULTS OR MOST RECENT LAB RESULTS
- MOST RECENT ECHO, EXT HEART MONITORING, 12-LEAD EKG, PULMONARY FUNCTION TESTING

ORDERING PROVIDER

Physician: _____ Dx: _____

Phone #: _____ Fax #: _____

Physician Signature: _____