

Central Ohio Cardiovascular Physicians (COCP) Referral Form

Drs. Amro, Gatto, Levin, Li, Patel, Susser
 For Questions Call: Lisa Brown at (614) 777-4508
 Fax Forms and Records: 614-777-4509
www.cocvc.com

Referral Information

ASAP (1-2 days)

Referral Doctor: _____

Phone #: _____

Sent by: _____

Date: _____

*If new referral DR please fill in **

*Address: _____

*City: _____

*State/Zip: _____

*Fax #: _____

*Medicaid #: _____

NPI #: _____

Patient Information

Patient: _____

Address: _____

City: _____

State/Zip: _____

Phone(Work): _____

Phone (Home): _____

SS#: _____

D.O.B: _____

Diagnosis: _____

Check Appointment Location:

Dublin Marysville
 Columbus Nelsonville

Please ensure the following:

Insurance card faxed (we are verifying coverage before appt)

Circle if Medicaid: Traditional/Anthem

Primary Insurance: _____
 Approval code for Nuclear Stress test if needed by insurance _____

Secondary Insurance: _____
 Approval code for Nuclear Stress test if needed by insurance _____

Patients instructed to bring all medications and supplements in original containers
 Patient's weight _____ / height _____
 EKG and Labs faxed

Preferred Physician

Amro Gatto Levin Li Patel Susser First Available

Service or Procedure Ordered

_____ **Cardiovascular Consultation**

_____ **Preoperative Cardiac Assessment**

Surgery Date _____

Surgeon _____

Stress Tests (**please precert nuclear stress tests)

_____ **Nuclear Stress Test (with nuclear images)**

_____ **Stress Echo**

_____ **Exercise Tolerance Stress Test (no images)**

Venous Color Duplex Studies

ASAP(exam same day or next am)

_____ **Upper Extremity**

R L B (circle)

_____ **Lower Extremity**

R L B (circle)

_____ **Holter Monitor** _____ **24 HR**

_____ **Event Recording** _____ **30 Day**

Arterial Doppler Studies- ABI & PVR

_____ **Upper Extremity**

_____ **Lower Extremity**

Ultrasound Studies

_____ **Echocardiography (2D/Color Doppler)**

_____ **Carotid Duplex Study**

ASAP(exam same day or next am)

 Referring Physician Signature

(This section to be completed by COCP)

Patient's appointment date: _____ Arrival time: _____ with Dr. _____

Location: _____ 6670 Perimeter Dr., Ste. 140 Dublin _____ 171 Morey Dr., Ste C Marysville
 _____ 5131 Beacon Hill Rd., Ste 120 Columbus _____ 1950 Mt. St. Marys Dr. Nelsonville (DHON)

Completed by: _____ Date faxed/ emailed back: _____

Thank you for your referral!