Electrophysiology Consult Referral Request Form

Mid Cities EP (Bedford) Clinic

Date: ____________________

Patient Name: ____ **DOB**: ____________________

Home Phone: ______________________________ **Day Phone**: ______________________________

Referring Physician: ____

Referring Phone: ____________________________ **Referring Fax**: ____________________________

Diagnosis/Reason for Referral: ____

Need Device Check First?: ❑ Yes ❑ No **What Brand is the Device**: ______________________

Appointment Date: ____________________

❑ Michael Eifling, MD **NPI**: 1295921989

Have you ever seen the physician before? (Either in the hospital or the office?)

❑ No ❑ Yes (Where?): ____

DEMOGRAPHICS:

Address: ____

City: ____ Zip: ______________________________

Insurance: ___________________________________ Secondary: ____________________________

ID: ____ Group: ________________________________

Insured: ____

Who is your PCP? ____

Records in Hold:

Echo Stress Test EKG EVM or Holter Tracings Office Notes

Fax To: 844-289-7694

4375 Booth Calloway, Ste. 400, North Richland Hills, TX 76180 * Phone: 682-292-9000 * Fax: 844-289-7694