CardioVascular Institute of South Texas

12340 Bandera Road, Suite 104
Helotes, Texas 78023
Phone: (210) 920-8000 Fax: (210) 920-6000
Web: http://www.cvistx.com

Referral Form

☐ **Imam E. Tjahja, MD, FACC** ☐ **Bruce T. Kuo, MD, FACC, FSCAI, RPVI**

Date:_____

Patient's Name: _____ DOB: _____/_____/_____

Address: _____

Phone: (_____) _____-_____

Primary Insurance: _____ Member ID# _____

Secondary Insurance: _____ Member ID# _____

	CARDIAC SERVICES
	Cardiac Consultation
	Echocardiogram
	Holter / Event Monitor
	Cardiac Stress Test
	Coumadin Clinic
	Pacemaker Clinic

	VASCULAR SERVICES
	Vascular Consultation
	ABI / Segmental Pressures
	Carotid Ultrasound
	Lower Extremity Arterial US
	Upper Extremity Arterial US

	VENOUS SERVICES
	Venous Consultation
	Venous Doppler for DVT/Reflux
	Vein Ablation
	Sclerotherapy

Please schedule: ☐ As Soon As Possible ☐ Next Available

			DIAGNOSIS		
	Abnormal EKG		Claudication (Pain in Limb)		Leg Swelling
	Atrial Fibrillation		Non Healing Ulcer		Deep Vein Thrombosis
	Chest Pain		Carotid Artery Stenosis / Bruit		Varicose Veins
	Dizziness / Syncope				Venous Ulcer
	Murmur				
	Palpitations				
	Shortness of Breath				
	Stroke / TIA				
	Other:		Other:		Other:

Please fax this referral form to our office at 210-920-6000 with patient demographics, insurance card(s) relevant clinic notes, recent labs, and recent ECG. *Thank you for referring your patient to us!*

OTHER REQUESTS: _____

OFFICE CONTACT PERSON: _____ ***PHONE:*** _____