# Cardiology Department-Jacksonville

1000 Brabham Avenue, Jacksonville NC 28546
Phone: 910-341-3464 Fax: 910-355-0166

Patient Referral Form for **Dr. Cyril Abrams**

***Please carefully complete referral form before a referral can be made***

Patient Last Name: _____ MI: ___ First: _____ DOB: _____

Address: _____ _____
Number and Street City, State & Zip

Home phone: _____ Cell #: _____ SS#: _____

Insurance-(Copy of Insurance Cards Requested). Please list all insurances or include copies of front and reverse of all insurance cards.

Primary: _____ #: _____

Secondary: _____ #: _____

Authorization Required Yes: ___ No: ___ Authorization #: _____ Contact: _____

Group NPI #: _____ Referring MD: _____ NPI#: _____

Address: _____ Phone: _____ FAX: _____

Primary Care Provider: _____ UPIN #: _____

Reason for Referral: Consult: ___ Bradycardia: ___ Tachycardia: ___ A-Fib: ___ Other: _____

_____

Specific questions you would like addressed in this consultation:

****REQUIRED WITH REFERRAL: Copy of Insurance Cards, Office notes/OP notes, medication bottles, previous Echo's and EKG reports.

Please allow several business days for records to be processed before the appointment can be made.

We have contacted your patient and scheduled this appointment.

Appointment Date: _____ Time: _____AM / PM

Prep date prior to procedure: _____ Time: _____ AM / PM

Revised: 3/28/2017