



NHI CLINIC REFERRAL AND ORDER FORM – GRAND ISLAND

Please complete this order form thoroughly. Fax this order form, the demographic information, copy of the insurance cards (both sides), office notes, and recent labs and tests to 308-381-8622.

Patient Name _____ M F DOB ____/____/____ SSN ____-____-____

Patient Address: _____ Patient City/State/Zip _____

Patient Home # _____ - _____ - _____ Patient Work # _____ - _____ - _____ Patient Cell # _____ - _____ - _____

Patient Insurance Carrier: _____ Insurance ID number: _____ Group Number: _____

Insurance Address: _____ Insurance City/State/Zip _____

Subscriber Name (if not patient) _____ M F DOB ____/____/____ SSN ____-____-____

Signs/Symptoms (medical necessity): (Check all that apply)

Requested Cardiologist: (circle one)

- Chest Pain, Chest Pressure, Fatigue, Dyspnea on Exertion, Weakness, Syncope, Hypertension, Hyperlipidemia, Atrial Fibrillation, Tobacco Use, Other, Murmur, Bruit, Visual Disturbance, Swelling, Claudication, Abdominal Pain, Renal Insufficiency, Leg Pain, Palpitations, Family Hx CAD, Hx of

- Friesen, Fruehling, King, Kosmicki

Requested Time for Appointment:

- First Available, Next Day, 48 hrs, 72 hrs, 1 week, Other

Consultation / Test Requested: HEIGHT: _____ WEIGHT: _____ BLOOD PRESSURE: _____ DIABETIC: Y N

- Consultation Only, Testing with Consultation, Echo, TEE (Transesophageal Echo), EKG, Vascular Study (specify), 24-Hour Holter Monitor, 30-Day Event Recorder (patient does not need to come to office – device to be mailed to patient), Heart Catheterization, Myocardial Perfusion Imaging, Stress Echo, Treadmill Only (Bruce Protocol), Treadmill (Bruce Protocol), Lexiscan, Dobutamine, Adenosine or Adenowalk, Dobutamine

Physician's Signature _____ Date ____/____/____ Form Completed by _____

Physician's Name (please print) _____ Phone (____) - ____ - ____ FAX (____) - ____ - ____

Nebraska Heart Institute, 3515 Richmond Circle, Grand Island, NE 68802 Scheduling Center: 308-381-1334 Fax: 308-381-8622

FOR NHI OFFICE USE ONLY: Appointment (date/time): _____ / _____ Arrival Time: _____ with Dr. _____ NHI Staff Initial _____ Date _____ Special Instructions: [] None [] Nothing to eat or drink: after midnight / _____ [] Other _____ [] NO caffeine, decaffeinated, or chocolate products 12 hours prior to the test