



NHI CLINIC REFERRAL AND ORDER FORM – NORTH PLATTE

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 308-534-7700.

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

Heirigs

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, 24-Hour Holter Monitor, 30-Day Event Recorder, 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, 102 McNeel Lane, Suite 1, North Platte, NE 69101 Scheduling Center: 308-534-1386 Fax: 308-534-7700

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