



Precision Heart Rhythm

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NEW PATIENT REFERRAL FORM

REFERRING PROVIDER

Provider Name: _____

Practice/Clinic: _____

Phone: _____

Fax: _____

PATIENT INFORMATION

Patient Name: _____

DOB: _____

Patient Phone: _____

Insurance: _____

REASON FOR REFERRAL (check all that apply)

☐ Atrial Fibrillation / Flutter

☐ SVT

☐ Ventricular Arrhythmia

☐ Bradycardia / Heart Block

☐ Palpitations

☐ Syncope / Near Syncope

☐ Device Evaluation (PPM/ICD/Loop)

☐ Ablation Consultation

☐ Medication Management

☐ Other: _____

URGENCY

☐ Routine

☐ Semi-Urgent (2-4 weeks)

☐ Urgent (<=72 hrs - please call)

ATTACH (if available):

☐ Office note

☐ EKG

☐ Echo

☐ Monitor

☐ Stress

☐ Cath/EP report

☐ Labs

☐ Discharge summary

CLINICAL SUMMARY / QUESTION FOR SPECIALIST

PATIENT CONSENT

☐ Patient has been informed of this referral and agrees to be contacted.

Referring Provider Signature: _____

Date: _____