St. Elizabeth HEALTHCARE

Advanced Heart Failure Management Center

Physician Referral Form

- Please email completed form and relevant clinical documentation to **HeartFailureReferral@stelizabeth.com**.
- Mail any additional imaging CDs and/or documentation to:
  Advanced Heart Failure Management Center; 1 Medical Village Drive, Edgewood, KY 41017
- **IF THIS IS AN URGENT REQUEST**, please call (859) 301-0124.

REASON FOR CONSULTATION

☐ Heart Failure Evaluation	☐ Advanced Heart Failure Options (Ventricular Assist Device)

PATIENT INFORMATION (PLEASE PRINT)

Patient Name:		Birth Date:
Home Phone:	Work/ Mobile Phone:	Gender: ☐ Male ☐ Female
Address:		
City:	State:	ZIP Code:
Preferred Language:		

REFERRING PHYSICIAN INFORMATION

Referring Physicians Name (Last, First):		Contact Name:
Office Address:		Email:
City:	State:	Zip Code:
Phone Number:	Fax Number:	

If available, please provide the following items with this form:

☐ Patient demographic sheet	☐ Most recent laboratory results
☐ Copy of insurance cards	☐ Previous cardiac testing
☐ Medication list	☐ Recent history and physical and social work notes

Questions? Contact (859) 301-0124, 24 hours a day, 7 days a week.
You will receive confirmation once the appointment is scheduled. Thank you for referring to St. Elizabeth Healthcare.

This form can be found online at stelizabeth.com/heartfailure.