UAB ADVANCED HEART FAILURE AND PULMONARY VASCULAR DISEASE PROGRAM

Thank you for your interest in the UAB Advanced Heart Failure and Pulmonary Vascular Disease Program. Your completion of all the fields below and attachment of medical records will ensure that there are no unnecessary delays in the evaluation of your patient.

Specific Reason for Referral: _____

Please mail or fax the noted information to our office.

- ☐ Patient demographics
- ☐ Copy of front/back of insurance cards (if available)
- ☐ Most recent cardiac/pulmonary testing reports (echocardiogram, left and/or right heart catheterization, pulmonary function testing)
- ☐ For testing that has associated images, please send a copy of the most recent testing via Vital Engine, by mail or with the patient. (Receipt of this imaging will not delay scheduling.)
- ☐ Most recent clinic note

Patient Name: _____

DOB: _____ SSN: _____ Phone: _____

Referring MD: _____ NPI: _____

Office Phone: _____ Office Fax: _____

Additional Remarks: _____

_____

Please note, we will contact the patient to notify them of the appointment details. If you would like to be notified, please check below and a fax notification will be sent to your office.

Appointment Notification Request: _____

Appointment Date: _____ Appointment Time: _____

The University of Alabama at Birmingham
Advanced Heart Failure Program
311 Tinsley Harrison Tower
1900 University Boulevard
Birmingham, Alabama 35294
Phone: 205-934-3438 • Fax: 205-975-9320
Physician Access Phone: 1-800-UAB-MIST

UAB MEDICINE