GREENVILLE HEALTH SYSTEM

ARRHYTHMIA CONSULTANTS **712 Grove Rd., 29605 864-522-1400**

New Patient Referral Request

Date of Request: _____

This information can be called to 522-1400 or faxed to our dedicated Referral Fax Line 864-522-1426.

Referring MD: _____

Practice Name: _____

Contact Person: _____

Phone #_____ Fax#_____

Patient Name: Mr./Mrs./Ms._____

SS#_____ DOB: _____

Address:_____

City_____ State_____ Zip_____

Home Phone: _____Work Phone: _____

Cell Phone: _____

Insurance: _____

Diagnosis/Reason for Referral: _____

Appt: Urgent: _____ within 1-2 weeks: _____ Next Available: _____

Weight: _____

Office Use Only:

Appointment Date: _____ ____ Time: _____

Electrophysiologist: _____

___Greenville Office

Faxed back to referring MD: _____

Date faxed: _____ Arrhythmia's contact person: _____