



DeBakey Heart & Vascular Center

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Fax Referral Form

To: From:

Fax: Pages:

Phone: Date:

Patient Name: _____

Patient Phone number: _____

Date of Birth (D/M/Y): _____

Consultation Type:

- Cardiology Consultation
Cardiac Surgery Consultation
Both

Valve Concern:

Three horizontal lines for text entry.

Referring Physician Signature

Cardiac Imaging

- 2D/3D Echo
Transesophageal Echo
Stress Echo
Cardiac CT
Cardiac MRI
Nuclear Imaging

Interventional Cardiology

- Balloon Valvuloplasty
Paravalvular Repair
ASD/PFO closure

Cardiac Surgery

- Valve repair
Valve replacement
Minimal access
Robotic-assist
Redo Valve