

Consultation Referral

Appointment Date: _____ Time: ____ with Dr.: ___

☐ First Available Physician

John Ambrose, MD, FACC

Cardiology

inspirehealth.org

2335 E. Kashian Lane, Suite 240 Fresno, CA 93701 559.320.0545 Office 559.825.8467 Referral Phone **833.973.5550 Referral Fax**

Testing Referral

Please include testing order

For testing only. Please mark one:

□ Carotid Ultrasound

Direct Referral Line

Fax Referral: 833.973.5550 | Phone: 559.825.8467

☐ Zaher Fanari, MD, FACC, FSCAI, FABVM	Echocardiogram Event monitor
☐ Mouatoua Mouanoutoua, MD	☐ Holter Monitor ☐ Nuclear Studies
☐ Henning Rasmussen, MD	□ Nuclear Studies □ Non-Walking □ Walking □ Rest/Stress ABI
☐ Ankit Rathod, MD	Stress EchocardiogramStress Test/TreadmillOther
Patient Demograph	hics
Patient Name:	DOB:
Home Phone: Cell Phone:	
Insurance:	
Diagnosis (required):	
Referring Physician:	
Phone: Fax :	
PCP (if different from referring):	
Required Patient Inform	mation
 ☐ HMO Referral - ☐ Authorization ☐ Patient Insurance Card and Demographics ☐ Medication List ☐ Most Recent Chart Notes, Lab Results 	
Appointment Update (UCC St	taff Use Only)
Your Patient is Scheduled at: 🛘 Clovis 🗘 Fresno	