

*School of Medicine*

Department of Medicine,  
Division of Cardiology  
Electrophysiology Section

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### PATIENT REFERRAL FORM

The following patient was seen in the Emergency Room on \_\_\_\_\_

Please schedule a follow-up appointment within \_\_\_ 1 week \_\_\_ 2 weeks \_\_\_ 1 month

Medical reason (s) for follow-up:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

#### PATIENT INFORMATION:

Name: \_\_\_\_\_ MRN: \_\_\_\_\_

DOB: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Requesting Physician \_\_\_\_\_ Date: \_\_\_\_\_

Primary Care Physician \_\_\_\_\_

Cardiologist \_\_\_\_\_

#### PATIENT INSTRUCTIONS:

Please call the above number for an appointment with Dr. \_\_\_\_\_ or  
another electrophysiologist at the Stony Brook Cardiac Arrhythmia Service.

**PLEASE FAX THIS FORM TO 631-444-1054 WITH THE RECORDS FROM  
THE EMERGENCY DEPARTMENT VISIT**