KENTUCKY CARDIOLOGY, PLLC

Avi Eres, MD, FACC, FSCAI, FSVM
Mubashir Qazi, MD, FACC, FSCAI

Date of Referral: _____

Patient Name: _____

Sex: Male _____ Female _____ Other_____

Date of Birth: _____ SS# _____

Marital Status:_____ Race:_____ Ethnicity:_____

Address: _____

City, State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Health Insurance Name: _____ ID# _____

Reason for Visit: _____

_____

Referring Physician Name:_____

Address: _____

City, State: _____ Zip Code: _____

Phone: _____ Fax: _____

Referring Physician's Direct Email Address: _____

Appointment Date: _____ Time:_____ Location:_____

ATTENTION!

MUST FAX A COPY OF MOST RECENT OFFICE NOTE, LABS, TESTING, MEDICATION LIST, AND INSURANCE CARD WITH THIS REFERRAL FORM TO **859-226-0041 ATTENTION: EVA.** WE WILL CONTACT THE PATIENT WITH THE APPOINTMENT DATE AND TIME WITHIN 24HOURS.

ACCREDITED FACILITY · IAC · NUCLEAR CARDIOLOGY · PET · ECHOCARDIOGRAPHY · VASCULAR TESTING

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