

# Referral Form

## Samsky Advanced Heart Failure Center

95 Collier Road, Suite 3000, Atlanta, Georgia 30309 | 404.605.1964



### Patient Information

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Date: \_\_\_\_\_ Gender:  Male  Female

Diagnosis: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Daytime Phone: \_\_\_\_\_

Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Phone: \_\_\_\_\_

Policy ID: \_\_\_\_\_ Name of Insured: \_\_\_\_\_

Attach front & back copy of insurance & RX Cards

### Requests (Check only one)

By Provider:	Referral Diagnosis:
All efforts will be made to accommodate physician requests.	Heart Failure
Dr. Benjamin DeMoss	
Dr. Arun Krishnamoorthy	
Dr. David Markham	
Dr. Rahul Loungani	
Dr. Rajeev Singh	
Dr. Catherine Marti	

**Special Requests:** (Check all that apply)  Wheelchair Assistance  Language Services  Other: \_\_\_\_\_

### Person Completing Form

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Email: \_\_\_\_\_ Phone: \_\_\_\_\_

### Referring Physician Information

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

Date: \_\_\_\_\_

Signature: \_\_\_\_\_

I hereby certify that the services above are medically necessary.

Please send in this referral form with the latest clinical notes, labs, and pertinent testing via fax to **404-367-5975** or email to **Lakeshia.Tillman@piedmont.org**