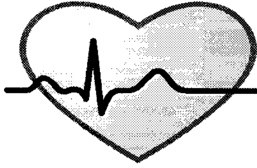

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ELISE HARTRANFT, C.R.N.P.

Consult Request Form

DATE OF REQUEST:______________________________

Referring Practice Name: ______________________________

Referring Practice Phone #:______________________________

Referring Physician Name:______________________________

PATIENT NAME:______________________________

DATE OF BIRTH:______________________________

REASON FOR CARDIOLOGY CONSULT REQUEST:
PLEASE EXPLAIN: ☐ Abnormal Test ______________

(IF PRE-OP, PLEASE LIST DIAGNOSIS AS TO WHY PATIENT IS HAVING SURGERY)

PHYSICIAN SIGNATURE: ______________________________

PLEASE FAX FORM TO : 717-358-9898

♥FAILURE TO RETURN THIS FORM MAY RESULT IN APPOINTMENT BEING CANCELLED♥

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Our Care Comes From the Heart ♥