Garland

Consult Referral Request Form

Date: _____

Patient Name: _____

Patient DOB: _____ Patient Phone: _____

Patient Current Diagnosis: _____

Patient Insurance: _____

HeartPlace Cardiologist:

Dr. John Bret

Dr. Peter Frenkel

Dr. Brent Patterson

Dr. L.K. Routh

Dr. Adam Reynolds

HeartPlace Electrophysiologist:

Dr. Sumeet Chhabra

Comments: _____

Please fax **patient demographics**, **medical records**, **insurance cards** to the appropriate Clinic Fax Number and include this form as the cover sheet. Your prompt attention to this matter is greatly appreciated. Thank You!!!

Fax To: 844-292-1462 Drs. Bret, Frenkel, Patterson, Routh

Fax To: 214-254-2259 Dr. Chhabra

700 Walter Reed Boulevard, Suite 208, Garland, TX 75042 | P: 972-276-8994 | F: 844-292-1462