



Richardson (Campbell)

## Consult Referral Request Form

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

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

Patient DOB: \_\_\_\_\_ Patient Phone: \_\_\_\_\_

Patient Current Diagnosis: \_\_\_\_\_

Patient Insurance: \_\_\_\_\_

### HeartPlace Physician:

Dr. Rajjit Abrol

Dr. Hootan Rahimizadeh

Dr. Gary Weingarden

Comments: \_\_\_\_\_

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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!!!

**Dr. Abrol - Fax To: 972-341-3403**

**Drs. Rahimizadeh/Weingarden - Fax To: 844-292-1459**