

## Referral Guidelines

**Cardiology:**

- ☐ First Available Provider
- ☐ Dr. Jude Gabaldon
- ☐ Dr. Stephen Mackerrow
- ☐ Dr. Stephen Bernard

**Cardiology and Vascular:**

- ☐ Dr. Faraz Sandhu

**Pulmonology:**

- ☐ First Available Provider
- ☐ Dr. Joseph Beier
- ☐ Dr. Patricia Hogan

\*\*Please ensure that all relative clinical information is sent with the referral. This will assist in scheduling the patient timely. We look forward to partnering with you to provide the best care for your patient.

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

Urgency: ☐ ROUTINE ☐ URGENT (Reason: \_\_\_\_\_)

Please include the following with the referral and fax to **505-599-4627** Attn: Referrals

**All Referrals:**

Reason for referral, Patient complete demographics (including insurance card(s) front and back), Current Medication list, Progress/Office visit notes, and labs within the last 1 year. Any/All previous cardiac/pulmonary diagnostic tests or procedures.

***Additional Specialty Specific Requirements pertaining to Referral: (Needed prior to scheduling)***

- ∞ Cardiac/Pulmonary Risk Assessment: Surgery type, Date of surgery, and name of surgeon.
- ∞ Vascular: Any diagnostic testing within the last year (ie. CT, CTA, Venous/Arterial US, ABI)
- ∞ Electrophysiology: Any diagnostic testing within the last year (ie. Echo, EKG/Telemetry, Holter Monitor/Event Monitor), Device Implant Information (if applicable)
- ∞ Pulmonology: CT, PFT, Sleep Study, NOC Oximetry, Allergy testing, ALL current DME information.
- ∞ Anti-Coagulation Clinic: Diagnosis, medication start date, dosage, therapeutic range, and duration.