Cardiology Second Opinion Physician Referral Form

Ann & Robert H. Lurie Children's Hospital of Chicago®

1. You can leave areas blank that are not applicable. Please email the completed form to **HeartCenter2ndOpinion@luriechildrens.org**.
2. Please send/fax OR reports, imaging reports, and clinical notes that apply. Fax to: **312.227.9640, ATTN: Silvana Illescas**
3. Imaging can be sent via Life Image.

If you have any questions, please contact us at PSO team at HeartCenter2ndOpinion@luriechildrens.org or 312.227.4240.

CLEAR FIELDS

PLEASE PRINT CLEARLY

PATIENT NAME	DATE OF BIRTH	SEX
REQUESTOR'S NAME		
RELATIONSHIP TO PATIENT	FAX	PHONE
CARDIOLOGIST	CURRENT/PAST CARDIAC SURGEON	
CURRENT TREATMENT CENTER	FAX	PHONE
PRIMARY CARE PROVIDER	FAX	PHONE
DIAGNOSIS		
CARDIAC MEDICAL/SURGICAL HISTORY		
CARDIAC SURGERY *(procedure, location, date)*		

IMAGING AND TESTING *(provide dates and receiving method; e.g., Care Everywhere, MyChart, fax, etc.)*

☐ ECG	DATE:	RECEIVING METHOD:
☐ ECHO	DATE:	RECEIVING METHOD:
☐ CARDIAC MR	DATE:	RECEIVING METHOD:
☐ CARDIAC CT	DATE:	RECEIVING METHOD:
☐ HOLTER/EVENT MONITOR	DATE:	RECEIVING METHOD:
☐ LABS	DATE:	RECEIVING METHOD:

NON-CARDIAC MEDICAL/SURGICAL HISTORY