Saint Agnes Medical Providers
Cardiothoracic Surgery

CARDIOTHORACIC REFERRAL

Dr. Birnbaum **Dr. R. Gregory** **Dr. Yankey**

Date of Referral:_____

Referring Doctor:_____ Phone:_____

Contact Person:_____

PATIENT NAME:_____ DOB:_____

Patient Phone:_____

Insurance:_____

CARDIAC Referral:

Date of Catheterization: _____ Hospital:_____

Echocardiogram:_____ Carotid:_____

Diagnosis:_____

THORACIC Referral:

CT of Chest:_____ Facility:_____

PET scan: _____ Facility: _____

Comments:_____
_____
_____
_____

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