

Advanced Heart Failure Center Referral Form

Patient Name: _____ DOB: _____

Referring Physician: _____

P: _____ F: _____

Office Contact Person: _____

Primary Care Physician: _____

Referring to:**Cardiologist/APP:** David Meggo, M.D. Pavel Buzadzhi, APRN Kayla Rials, PA-C
 Steven C. Stroud M.D. Deborah Crawford, APRN Stephanie Short, APRN**Surgeon/APP:** Ajit Tharakan, M.D.

- Urgent (1-2 weeks)
- Standard (up to 3 months)
- No Preference

Please check the program you are referring the patient to:

- Outpatient Advanced Heart Failure Center
- Left Ventricular Assist Device (LVAD)
- Pulmonary Arterial Hypertension (PAH)
- Amyloidosis

Please fax all medical records, including the most recent information listed below, to 918-574-9059, ATTN: Intake Coordinator

- ✓ Demographics and Insurance Card
- ✓ Most Recent Office Visit Notes
- ✓ Cardiac Diagnostic Testing Reports
- ✓ Current Medication List
- ✓ Other Applicable Clinical Information

Please mail disks with images to:

Advanced Heart Failure Center
Oklahoma Heart Institute - hospital, G level
1120 S. Utica Ave.
Tulsa, OK 74104