Providence SWEDISH
Swedish Medical Group

P 206-215-4545
F 206-215-4550

Advanced Cardiac Support Program Referral Form

START DATE	END DATE	AUTHORIZATION REQUIRED? ☐ YES ☐ NO
REFERRAL TYPE	☐ CONSULT ONLY ☐ EVALUATE AND TREAT	NUMBER OF VISITS REQUESTED

Referring Provider: _____

Primary Contact: _____

Facility Name: _____

Contact Phone: _____

Phone Number: _____

Fax Number: _____

Requesting consultation for:

- ☐ Heart failure with reduced ejection fraction
- ☐ Heart failure with preserved ejection fraction
- ☐ Consideration for LVAD (Left Ventricular Assist Device)
- ☐ Concern for, or established diagnosis of, Cardiac Amyloidosis
- ☐ Concern for, or established diagnosis of, Cardiac Sarcoidosis
- ☐ Hypertrophic Cardiomyopathy
- ☐ Other: _____

PATIENT NAME	PRIMARY PHONE NUMBER	DOB	SSN
ALTERNATE PHONE	MAILING ADDRESS	PRIMARY CONTACT *(IF OTHER THAN PATIENT)*	

Please complete insurance information below OR include copies of insurance card (front and back) with referral form.

Primary Insurance: _____

Phone Number: _____

Member ID: _____

Group Number: _____

Secondary Insurance: _____

Phone Number: _____

Member ID: _____

Group Number: _____

Additional Insurance: _____

Phone Number: _____

Member ID: _____

Group Number: _____

In addition to the referral form, please include the following additional information to ensure timely scheduling:

- Recent office visit notes
- Recent hospitalization records
- Recent operative reports if applicable
- Recent blood work
- Transthoracic Echocardiogram (TTE) Reports and Images
- Transesophageal Echocardiogram (TEE) Reports and Images
- Recent EKG
- Ambulatory Heart Rhythm Monitor reports with tracings
- Cardiac Catheterization Reports and Images
- Recent PFT report

Advanced Cardiac Support Program
1600 E Jefferson, Suite 600, Seattle, WA 98122

HI-23-0091 5/23