THE
University of Vermont
Children's Hospital

Pediatric Cardiology - Patient Consult Request

PEDIATRIC CARDIOLOGY
Main Campus
111 Colchester Avenue
Patrick 581
Burlington, VT 05401
PHONE (802) 847-8950
FAX (802) 847-7231

Nancy A. Drucker, MD
Niels Giddins, MD
Scott B. Yeager, MD
Melinda Hess, RN, BSN
Brenda Fife, RN, BSN
Rebecca Brayden, RN, BSN

It is our goal to be prepared for your patient's first visit in order to provide them with the best possible care. Please complete this form so we will have all the necessary information for their visit.

The patient is being referred for:

- ☐ Office Visit
- ☐ Echocardiogram Only: If you are requesting an **echocardiogram only**, please contact our office at 802-847-8950.

Patient Name:_____

Date of Birth:_____

Mailing Address:_____

Phone Number:_____

Parent/Guardian:_____

Insurance Carrier & Certificate Number:_____

Is an insurance referral required? ☐ no ☐ yes (please attach)

Reason for Consult:_____

Have any of the following tests been done outside of UVM Medical Center?

- ☐ EKG (electrocardiogram); if yes, please attach copy of report
- ☐ Echocardiogram (cardiac ultrasound); if yes, please attach copy of report
- ☐ Holter Monitor; if yes, please attach copy of report
- ☐ Event Monitor; if yes, please attach copy of report
- ☐ Chest X-Ray; if yes, please attach copy of report, and, if available, please have the x-ray pushed through the PACS system
- ☐ Labs; if yes, please attach copy of report(s)

Please attach last office note, relevant ER records and previous cardiology records (if applicable)

Physician Requesting Consult:_____

Phone Number:_____ Fax Number:_____