



12 Commons Street, Rutland, VT 05701 | www.RRMC.org | 802.747.3600 | Fax 802.773.8501

### REFERRAL FORM

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_  
(last 4 digits)

Address \_\_\_\_\_

Preferred phone: \_\_\_\_\_

Primary Insurance Name: \_\_\_\_\_ Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Secondary Insurance Name: \_\_\_\_\_ Policy # \_\_\_\_\_ Group # \_\_\_\_\_

**DIAGNOSIS/REASON FOR VISIT:** \_\_\_\_\_  
*Must be included to schedule appointment*

**Referring MD:** \_\_\_\_\_

Fax #: \_\_\_\_\_ Phone #: \_\_\_\_\_

Office Consult (CIRCLE ONE): Dr. A Coleman Dr. M. Robertello Dr. S. Shapiro

Office Consult = First Available

Event Monitor (30 days): →  Auto Trigger  Non-Auto Trigger

Zio  7 Days  
 14 days

Holter Monitor: →  24 hr  48 hr

Other Testing: →  EKG  Echocardiogram

Stress Testing: →  ETT (Exercise Tolerance Test)  
 Nuclear →  Treadmill  Lexiscan  
 Stress Echo →  Treadmill  Dobutamine

**Patient Weight (REQUIRED for Stress Testing):** \_\_\_\_\_ **lb/kg (please specify)**

**Physician Signature:** \_\_\_\_\_ **Date/Time:** \_\_\_\_\_

**Appt Date:** \_\_\_\_\_ **Appt Time:** \_\_\_\_\_ **RHC Staff to Return to Provider via Fax**