[Your Clinic/Facility Name]
[Your Clinic/Facility Address]
[City, State, Zip Code]
[Phone Number]
[Email Address]
[Date]
Patient Information:
- **Name:** [Patient's Full Name]
- **Date of Birth:** [MM/DD/YYYY]
- **Medical Record Number:** [MRN]
Referring Physician:
- **Name:** [Referring Physician's Full Name]
- **Facility:** [Referring Physician's Clinic/Hospital Name]
- **Contact Number:** [Phone Number]
Reason for EKG Request:
[Brief description of symptoms, history, or reason for EKG]
Clinical Information:
- [List any relevant medical history, current medications, or previous EKG results]
Requested Procedure:
- Electrocardiogram (EKG/ECG)
Additional Notes:
[Specify any additional instructions or considerations]
Signature:
[Referring Physician's Signature]
NPI Number: [NPI]
Date: [MM/DD/YYYY]
Attachments:
[Attach any necessary documentation or forms]