CHILDREN'S HEART SPECIALISTS, PSC
TELEPHONE (502) 584-3200 TOLL FREE 877-3-MURMUR
FAX (502) 584-1465 OR 584-3333
www.MyKentuckyHeart.com

REFERRAL FORM
PHASE I

1. DATE_____ BY _____
2. PATIENT'S NAME_____ DOB_____SEX_____
3. LEGAL CUSTODIAN_____RELATIONSHIP_____
4. ADDRESS_____
5. CITY_____STATE_____ZIP_____
6. PHONE NUMBER (_____)_____CELLULAR # (_____)_____
7. INSURANCE CARRIER_____

   REFERRAL ID#_____ ID#_____
8. REFERRING DOCTOR_____ NPI#_____

   PHONE NUMBER (_____)_____ FAX (_____)_____
9. REASON FOR REFERRAL (CV CONSULTATION): _____
10. CHS OFFICE SITE? LOUISVILLE-731E BROADWAY E-TOWN
    DANVILLE BARDSTOWN SHELBYVILLE LaGRANGE

    OTHER_____

PHASE II

++PLEASE FAX THIS FORM TO DR. JUAN VILLAFAÑE AT (502) 584-1465

PHASE III

DR. VILLAFAÑE'S OFFICE WILL FAX YOU A SCHEDULED DATE
(Be sure you specify your fax number and/or phone number)

Scheduled Date_____Time_____Clinic_____

PLEASE VISIT OUR WEBSITE www.MyKentuckyHeart.com for directions to our offices and helpful information to you and your patient.