ARKANSAS CHILDREN'S HOSPITAL PEDIATRIC CARDIOLOGY CLINIC

(501) 364-2008 PHONE (501) 364-3667 FAX

Date: ______________________________ Has the patient ever been seen at ACH? _______________

Patient name : _____________________________________ Gender _______ Age ________DOB: _____________________

SSN: ____________________________ Language: ______________________ Interpreter needed: ____________________

Mom's name: _____________________________________ Dad's name: ____

Guardian: ____

Patient's address: ____
(Street) (City) (State) (Zip)

Home phone#: _____________________ Mom's work#: ______________________ Dad's work#: _____________________

Parent's cell phone#: _______________________ Message phone#: _________________________________

Referring physician: ____ Phone#: _____________________________

Address: ____ Fax#: ______________________________

PCP: ____ PCP phone#: _________________________________

Name of insurance: _____________________________________ Subscriber name: _________________________________

Insurance address: ____ Insurance ID#: ________________________

Insurance phone#: ____ Referral needed? ________________________________

****IF PATIENT NEEDS A REFERRAL, PLEASE SEND WITH INTAKE FORM****

Diagnosis: ____

If any of the following tests were done please send a copy of report with intake form: EKG, ECHO, HOLTER MONITOR or LAB.

Chest x-ray: _____________________ **(FAMILY MUST BRING ORIGINAL FILMS TO THE CLINIC VISIT)**

Name and title of person filling out form: _______________________________________ Contact#: ____________________

ACH USE ONLY

Date received: ___________________________ Date scheduled _________________________ By: ___________________

UNIT #: _____________________________APPOINTMENT DATE/TIME: ____

REPORTS RECEIVED: EKG___________ ECHO___________ HOLTER MONITOR___________ LAB______________

REFERRAL RECEIVED: _____________________ INTERPETER ORDERED: ______________________