

Advanced Heart Failure Center Referral Form

Patient Name: _____ DOB: _____

Referring Physician: _____

P: _____ F: _____

Office Contact Person: _____

Primary Care Physician: _____

Referring to:

Cardiologist/APP: Mrudula Munagala, M.D. Shahid Qamar, M.D. Hoda Butrous, M.D.
 Debbie Crawford, APRN Kristin Pruitt, APRN Bethany Bigby, PA

Surgeon/APP: Allen Cheng, M.D. Ajit Tharakan, M.D Alberto Trinidad, APRN

- Urgent (1-2 weeks)
- Standard (up to 3 months)
- No Preference

Please check the program you are referring the patient to:

- Outpatient Advanced Heart Failure Center
- Left Ventricular Assist Device (LVAD)
- Pulmonary Arterial Hypertension (PAH)
- Amyloidosis
- Cardiac Oncology

Please fax all medical records, including the most recent information listed below, to 918-574-9059, ATTN: Intake Coordinator.

- ✓ Demographics and Insurance Card
- ✓ Most Recent Office Visit Notes
- ✓ Cardiac Diagnostic Testing Reports
- ✓ Current Medication List
- ✓ Other Applicable Clinical Information

Please mail disks with images to:

Advanced Heart Failure Center
Oklahoma Heart Institute - hospital, G Level
1120 S Utica Ave
Tulsa, OK 74104