Oklahoma Heart Institute

# Advanced Heart Failure Center Referral Form

Patient Name: _____DOB:_____

Referring Physician: _____

P: _____ F:_____

Office Contact Person:_____

Primary Care Physician:_____

**Referring to:**

**Cardiologist/APP:** ☐ Hoda Butrous, M.D. ☐ Debbie Crawford, APRN ☐ Kristin Pruitt, APRN ☐ Kayla Rials, PA

**Surgeon/APP:** ☐ Ajit Tharakan, M.D

- ☐ 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

**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