



HEART CENTER

**PHYSICIAN FAX REFERRAL**

Please fax to (256) 840-4585

For Scheduling questions call (256) 840-4580

HH Heart Center-Boaz  
2525 US Highway 431, Suite 130  
Boaz, AL 35957

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**REFERRING PHYSICIAN**

Physician Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

Clinic Contact: \_\_\_\_\_ Fax: \_\_\_\_\_

Reason for Appointment: \_\_\_\_\_

**PATIENT INFORMATION-please include demographic sheet with faxed records**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Patient contact Number: Home# \_\_\_\_\_ Cell# \_\_\_\_\_

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**REQUESTED PHYSICIAN**

- FIRST AVAILABLE**
  - George Philip, MD
  - Maan Harb, MD
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**FOR OFFICE USE ONLY**

**Appointment made with:** \_\_\_\_\_ **Date:** \_\_\_\_\_ **Time:** \_\_\_\_\_