

PHYSICIAN FAX REFERRAL

Please fax to (256) 216-1920 For Scheduling questions call (256) 233-9273 Option 2

HH Heart Center – Athens

101 Fitness Way, Suite 2700 Athens, AL 35611

REFERRING PHYSICIAN		
Physician Name:	Telephone:	
Clinic Contact:	Fax:	
Reason For Appointment:		
PATIENT INFORMATION – please inclu	de demographic sheet with records	
Patient Name:	Date of Birth:	
Patient Contact Number: Home#	Cell#	
DEOLIECTED BUYCICIAN Adams I acco	4:	
REQUESTED PHYSICIAN – Athens Loca	tion	
□ Crystal Walker, MD		

FOR OFFICE USE ONLY		
Appointment Made with	Date:	Time: