

**HH Heart Center – Fort Payne**

306 Medical Center Drive SW

Fort Payne, AL 35968

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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** Wael Halaseh, MD

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**FOR OFFICE USE ONLY****Appointment Made with** \_\_\_\_\_ **Date:** \_\_\_\_\_ **Time:** \_\_\_\_\_