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: ☐ David Meggo, M.D. ☐ Pavel Buzadzhi, APRN ☐ Kayla Rials, PA-C
☐ Steven C. Stroud M.D. ☐ Deborah Crawford, APRN ☐ Stephanie Short, APRN

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