



CEDARS-SINAI
HEART INSTITUTE

HYPERTENSION CENTER REFERRAL INTAKE FORM

Patient Name: _____

You will receive a consultation report, including recommendations for optimizing medical therapy, within 48 hours of your patient’s visit to the Cedars-Sinai Hypertension Center.

| REASON FOR REFERRAL | SERVICES REQUESTED |
|---|--|
| <ul style="list-style-type: none"> <input type="radio"/> Difficult to Control Hypertension <input type="radio"/> Secondary Hypertension (Known or Suspected) <ul style="list-style-type: none"> <input type="radio"/> Primary Aldosteronism <input type="radio"/> Pheochromocytoma/Paraganglioma <input type="radio"/> Renal Parenchymal Hypertension <input type="radio"/> Renovascular Hypertension <input type="radio"/> Labile Hypertension | <ul style="list-style-type: none"> <input type="radio"/> Ambulatory Blood Pressure Monitoring and Report <input type="radio"/> Consultation ONLY Without Management <input type="radio"/> Consultation With Initiation of Management <input type="radio"/> Adrenal Vein Sampling (AVS) |

Physician Comments: _____

Referring Physician Name: _____

Referring Physician Signature: _____

Referring Physician Telephone: _____

CALL (310) 423-2726 (OPTION 3) FOR AN APPOINTMENT.

Telephone: 310-423-2726 | Fax: 310-423-6795 | cedars-sinai.edu/hypertension