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

o Difficult to Control Hypertension
o Secondary Hypertension (Known or Suspected)
  ○ Primary Aldosteronism
  ○ Pheochromocytoma/Paraganglioma
  ○ Renal Parenchymal Hypertension
  ○ Renovascular Hypertension
  ○ Labile Hypertension
	o Ambulatory Blood Pressure Monitoring and Report
	o Consultation ONLY Without Management
	o Consultation With Initiation of Management
	o 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