820 ST. SEBASTIAN WAY
SUITE 2A
AUGUSTA, GA 30901
706.722.1249
706.722.1947 FAX

Transfer of Implantable Cardiac Device Monitoring

Date: ___________________

Patient Name: _______________________________

DOB: _________________________

I, _________________________, am requesting to have my implantable cardiac device monitoring transferred to Dr.___________________. This request is effective as of __________________. Please remove me from University Health Care System's Cardiac Device Clinic, as well as, remote monitoring system.

Sincerely,

____
Patient Name

____
Patient Signature