HEART of AUSTRALIA

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REFERRAL

Patient Name: _____

Gender: Male / Female Date of Birth: ____/____/____

Ethnicity: [ ] Aboriginal [ ] Torres Strait Islander [ ] Other: _____

Wheelchair Access: [ ] Yes [ ] No
Hearing Impaired: [ ] Yes [ ] No
Sight Impaired: [ ] Yes [ ] No

Contact Details

Home: _____ Work: _____ Mobile: _____
Preferred Contact Number: [ ] Home [ ] Work [ ] Mobile

Email: _____

Address: _____

Your doctor has recommended that you use Heart of Australia. You may choose another provider but please discuss this with your doctor first.

Referring Doctor Details:

Name: _____

Provider No: _____

Phone: _____

Fax: _____

Address: _____

Date: ____ / ____ / _____ **Signature:** _____

Services Requested

Cardiology
[ ] Cardiology Consultation
[ ] ECG
[ ] Transthoracic Echocardiogram
[ ] **Exercise Stress Echocardiogram**
[ ] **Exercise Stress Test (ECG)**
[ ]24 Hour Holter Monitor
[ ] 24 Hour Blood Pressure Monitor

Respiratory
[ ] Complex Respiratory Function Test

Sleep
[ ] Sleep Study (In-home Sleep Apnoea Testing)

[ ] **Other** (Please Specity): _____

Clinical Details

_____

_____

_____