

REFERRAL

Patient Details

Title: Mr / Mrs / Miss / Mstr / Other _____ Surname: _____
Date of Birth: ____ / ____ / _____ First Name: _____

Contact Details

Home No: _____ Mobile No: _____
Email Address: _____
Residential Address: _____
State: _____ Postcode: _____

Referring Practitioner Details

Name: _____ Phone: _____
Provider No: _____ Fax No: _____
Address: _____ Signature: _____ Date: ____ / ____ / _____

Clinical Notes

Examination Required

Cardiology <input type="checkbox"/> ECG <input type="checkbox"/> 24 Hour Blood Pressure Monitor <i>(applicable only once in any 12-month period)</i> <input type="checkbox"/> Exercise Stress Test - 11729 or 11730 <i>(applicable once every 2 years)</i> + / - cardiac consultation if required <input type="checkbox"/> Exercise Stress Echocardiogram <input type="checkbox"/> Initial – 55141 <i>(once every 2 years)</i> <input type="checkbox"/> Repeat – 55143 <i>(once every 12 months)</i> + / - cardiac consultation if required	Holter Monitoring <i>(applicable once in any 4-week period)</i> <input type="checkbox"/> 24 hour <input type="checkbox"/> 7 days Other (please specify) _____
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Echocardiogram

INITIAL - 55126 <i>(applicable once every 2 years)</i> Please select indications: <input type="checkbox"/> Symptoms or signs of cardiac failure <input type="checkbox"/> Ventricular hypertrophy or dysfunction <input type="checkbox"/> Valvular disease <input type="checkbox"/> Aortic disease <input type="checkbox"/> Pericardial disease <input type="checkbox"/> Thrombotic disease <input type="checkbox"/> Embolic disease <input type="checkbox"/> Heart tumour <input type="checkbox"/> Symptoms/signs congenital heart disease <input type="checkbox"/> Other (privately billed, no Medicare) _____	REPEAT <i>(used if 55126 claimed within last 2 years)</i> Please select indications: <input type="checkbox"/> Known Valvular disease. <i>(Specialist 55127 GP MM3-7 55128)</i> <input type="checkbox"/> Known heart failure or structural heart disease <i>(Specialist only 55129)</i> <input type="checkbox"/> Isolated pericardial effusion (55133) <input type="checkbox"/> Pericarditis (55133) <input type="checkbox"/> Cardiotoxicity (55133) <input type="checkbox"/> 17 years & under complex congenital heart disease <i>(Specialist only 55132)</i> <input type="checkbox"/> Other (privately billed, no Medicare) _____
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