BARWON HEALTH CARDIOLOGY
OUTPATIENT DIAGNOSTIC REFERRAL

UR No: ……………………………………………………………

Name: ……………………………………………………………..

DOB: ……………………………………………………………..

Address: …………………………………………………………

Complete or place Patient Identification Label here.

ALL DETAILS MUST BE ENTERED

Incomplete referrals will not be processed

PATIENT DETAILS (*Essential information*)

PHONE NO: ……………………… MOBILE NO: ……………………

HEIGHT: ………….. CM WEIGHT: ……………………KG

MOBILITY: ☐ Independent ☐ Aid required (please indicate aid type) ……………………………………………………………..

REFERRING DOCTOR

Name (Please print): ……………………………………………………… Signature: ……………………………………………………

Provider No: ………………………… Copy of report to: …………………………………………………. DATE: …….. / ………/ ………..

EXAMINATION REQUIRED (*Please tick all relevant boxes*)

TRANSTHORACIC ECHO

- ☐ ROUTINE STUDY
- ☐ COMPLEX CONGENITAL STUDY
- ☐ CLOZAPINE STUDY
- ☐ SALINE BUBBLE STUDY (PFO / ASD)
- ☐ CONTRAST STUDY (Cardiologist referral only)
- ☐ STRESS ECHO

OTHER

- ☐ ECG
- ☐ EXERCISE ECG (Treadmill)
- ☐ HOLTER MONITOR (24hrs)
- ☐ EVENT MONITOR (6 days)
- ☐ BLOOD PRESSURE MONITOR (24hrs)
- ☐ TILT TABLE

HISTORY/CLINICAL DETAILS:

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Office use Only:
ASSESMENT PRIORITY

☐ category 1 ☐ category 2 ☐ category 3 ☐ category 3B

Date Received: ………………………… Date Triaged: ……………………………….. Date Checked: ………………………………..

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