

Cardiac Investigation Referral

Bairnsdale Regional Health Service
Day St., Bairnsdale (Consulting Rooms)

Bookings: Phone: 5150 3478

Fax: 5150 3404

In-patient

URGENT (please phone the tech)

Referring Doctor's details:

Dr. _____

Signature: _____

Clinic: _____

Date of referral: ____/____/____

cc: BRHS Medical Records

cc: _____

Patient details:

Name _____

Date of Birth: _____

Address: _____

Phone: _____

test info: www.gcardiactech.com.au

Test(s) requested:

- Echocardiogram
- Echocardiogram with Saline Contrast study
- Stress Echocardiogram **Beta Blockers to be ceased 2 days prior: Yes / No**
- Holter Monitor 24Hr 48Hr 3Day 7Day*
- Ambulatory Blood Pressure Monitor 24Hr*

(*Bulk billing not available for BP Monitor or 7Day Holter)

Indication:

- AF
- IHD
- Systolic Murmur
- Diastolic Murmur
- Collapse/LOC
- Presyncope
- CCF
- Chest Pain
- SOB
- SOBOE
- Palpitations
- Pre-op

Past medical history:

- CABG (year ____)
- Coronary Stent
- Stroke
- AF
- Valve surgery (year ____)
- MI
- NSTEMI
- PPM
- AICD

Further details:

A legible signed and dated referral is a legal requirement for testing to proceed.

To the patient: Your doctor has requested that you undergo testing at Gippsland Cardiac Tech. You may use another provider, but please discuss this with your doctor first.