REFERRAL FORM

SUBMIT FORMS BY EITHER FAX, PHONE, EMAIL OR VIA THE WEBSITE

Ph: 0474771927
Fax: 0386773335
web: www.otwayheart.com.au
email: jayne.graves@otwayheart.com.au

Patient name: Date of Birth:

Address: Home Telephone:
Medicare Number: Mobile Phone:
Location: ☐ Colac ☐ Apollo Bay ☐ Lorne

Test Request :

- ☐ Echocardiogram (Echo)
- ☐ Electrocardiogram (ECG)
- ☐ Stress Echocardiogram (Stress Echo)
- ☐ 24 hr Holter Monitor ECG (Apollo Bay and Lorne only)

Clinical indication:

- ☐ Murmur
- ☐ Short of breath
- ☐ Chest pain
- ☐ Palpitations / arrhythmia / Pacemaker
- ☐ Family history of heart disease
- ☐ Hypertension / Hypotension
- ☐ Source of embolus / TIA
- ☐ Hypercholesterolaemia
- ☐ Diabetes
- ☐ Previous cardiac surgery
- ☐ Pre – op assessment
- ☐ Other:

Clinical notes/Medications:

Referring Doctor:
Provider Number:
Address:
Phone / Fax:
Email:
Signature:_____ Date:_____

APOLLO BAY
1 Moore Street, Apollo Bay 3233
LORNE
Lorne Medical Centre, 230 Mountjoy Parade, Lorne 3232
COLAC
28 Hart Street, Colac 3250