

BOOK NOW



MEDICAL HISTORY

- ☐ Prior myocardial infarct
- ☐ Prior coronary stent/angioplasty
- ☐ Coronary bypass graft
- ☐ Heart failure
- ☐ Currently on beta blockers/ anti-arrhythmics
- ☐ Currently taking ACE inhibitor
- ☐ Pacemaker
- ☐ Diabetes
- ☐ Renal impairment
- ☐ Myeloma

IMAGES

- ☐ Online
- ☐ CD
- ☐ Printed

REPORT

- ☐ Electronic download
- ☐ Fax

PATIENT DETAILS

Patient name: _____

Birth date: _____

Address: _____

Phone: _____ Mobile: _____

EXAMINATION REQUESTED

- | | | |
|--|--|---|
| ☐ CT coronary angiogram | ☐ MRI cardiac | ☐ Carotid doppler |
| ☐ CT coronary calcium score | ☐ Other studies | ☐ CTLA |
| ☐ Echocardiogram | ☐ Cardiac perfusion | ☐ MIBI ☐ Others |

CLINICAL DETAILS/REGION TO BE EXAMINED

REFERRAL ELIGIBILITY

SPECIALIST REFERRAL (Medicare eligible)

One of the following criteria must be present (please tick where appropriate):

CT (BULK BILLED)

- ☐ Patient has stable symptoms consistent with coronary ischaemia, is at low to intermediate risk of coronary artery disease and would have been considered for invasive coronary angiography.
- ☐ Patient requires exclusion of coronary artery anomaly or fistula.
- ☐ Evaluation of coronary arteries prior to non-coronary cardiac surgery.

MRI (BULK BILLED*)

- ☐ Congenital cardiac
- ☐ Cardiac tumour
- ☐ Thoracic aorta abnormality
- ☐ First degree relative with confirmed ARVC
- ☐ ARVC/ARVD findings/ symptom assessment - exclude arrhythmogenic right ventricular cardiomyopathy: right and left ventricular analysis will be performed

MRI (Non Medicare eligible)

- ☐ Function and viability
- ☐ Hypertrophic cardiomyopathy
- ☐ Dilated cardiomyopathy
- ☐ Myocarditis or pericarditis (other causes)

**Some clinics and procedures may require a gap payment. Any additional costs will be advised by the bookings team when placing an appointment.*

REFERRED BY

Name: _____

Address: _____

Phone: _____ Fax: _____

Provider number: _____

Signature: _____ Date: _____

Send copy to: _____