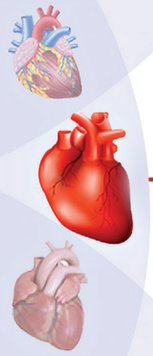

HEART CARE MACKAY REFERRAL FORM

Suite 13,
Mater Medical Centre
76 Willetts Rd
Mackay, QLD 4740

Ph: (07) 49 424 756
Fax: (07) 49 424 772
Email: admin@heartcaremackay.com.au

PATIENT NAME: ..... DATE OF BIRTH: .....

ADDRESS: .....

MOBILE: ..... PHONE: .....

MEDICARE NO: .....

REQUEST FOR EXAMINATION:

- ☐ ECHOCARDIOGRAM (TTE)
- ☐ EXERCISE STRESS TEST (EST)
- ☐ EXERCISE STRESS ECHO (ESE)
- ☐ HOLTER MONITOR
- ☐ AMBULATORY BLOOD PRESSURE MONITOR (ABPM)
- ☐ 7 DAY EVENT MONITOR
- ☐ ECG
- ☐ CORONARY ANGIOGRAPHY

CLINICAL DETAILS (including history and clinical findings):

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.....

.....

REFERRING DOCTOR: .....

PROVIDER NUMBER: .....

PRACTICE/LOCATION: .....

PHONE: ..... FAX: .....

SIGNATURE: ..... DATE: .....

YOUR PRACTICE STAMP