NORTHSIDE
CARDIOLOGY

Northside Cardiology
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PATIENT DETAILS

Name:	Phone / Mobile:	
D.O.B:	Medicare Number:	Ref:
Address:		

CONSULTATION REFERRAL

Consultant Cardiologist	☐ Consultation

DIAGNOSTIC REQUEST FORM (Please Tick Appropriate Boxes Below)

STUDY REQUESTED	INDICATIONS	
☐ **Echocardiogram**	☐ Symptoms or signs of heart failure	☐ Aortic disease
	☐ Ventricular hypertrophy or dysfunction	☐ Congenital heart disease
	☐ Pulmonary hypertension	☐ Cardiac tumour or thrombus
	☐ Valvular disease	☐ Cardiac source of embolus
	☐ Pericardial disease	
	☐ OTHER INDICATION – NO MBS REBATE	
☐ **Stress Echocardiogram**	☐ New typical or atypical angina	☐ Known coronary disease with worsening symptoms
	☐ ECG changes consistent with coronary disease	☐ Coronary CT or invasive angiogram lesions of uncertain significance
	☐ Exertional dyspnoea of uncertain aetiology	☐ Silent ischemia –limited history or exercise tolerance
	☐ Preoperative assessment before valve surgery ☐ Severe aortic stenosis ☐ Severe valvular regurgitation	☐ Preoperative assessment before MAJOR non cardiac surgery ☐ AND low functional capacity < 4 METS AND presence of any 2 of: ☐ Heart Failure ☐ Ischemic heart disease ☐ Renal impairment eGFR <60 ☐ Diabetes on insulin ☐ Stroke/TIA
	☐ OTHER INDICATION – NO MBS REBATE	
☐ **24 Hour Holter Monitor**	☐ Unexplained syncope or presyncope	☐ Palpitations > 1 episode per week
	☐ Suspected arrhythmia > 1 episode per week	☐ Surveillance post cardiac surgery known to cause arrhythmia
	☐ Pulmonary hypertension	
	☐ OTHER INDICATION – NO MBS REBATE	

☐ **24 Hour Blood Pressure Monitor No MBS Rebate**	
☐ **ECG – 12 Lead** ☐ **Trace and Report**	

CLINICAL HISTORY Include previous cardiac diagnostic test results (if known)

☐ **Hypertension**	☐ **Diabetes**	☐ **Dyslipidaemia**	☐ **Smoker**	☐ **Family History**

REFERRING DOCTOR'S DETAILS

Name:	Provider Number:	
Address:		
Phone:	Fax:	Email:
Signature:	Date	
Copies to:		