Cardiac And Vascular
Diagnostic Centre Chermside

For all appointments & reports
T: (07) 3350 2222 F: (07) 3350 2777
E: cardiacdiagnosticschermside@gmail.com
811 Gympie Road, Chermside QLD 4032

EXAMINATION NEEDED:

Cardiac Investigations

- ◻ Echocardiography
- ◻ Holter Monitor (24hr)
- ◻ ECG (Reported)
- ◻ Exercise Stress Echocardiogram**
- ◻ 24 Ambulatory Blood Pressure Monitor
- ◻ Consultation with Cardiologist

*** For diagnostic exercise testing, patients should discontinue beta blockers, digoxin, verapamil and diltiazem 48 hours prior to testing.*

PATIENT DETAILS

Patient Name: ______________________________ Date of birth: ___________________________

Residential Address: ____

Phone number: _____________________________

Medicare No.: ______________________________

MEDICARE CRITERIA for TESTING:

Please tick appropriate Symptoms

- ◻ **Shortness of breath**
- ◻ **Chest pain**
- ◻ **Pre-syncope**
- ◻ **Syncope**
- ◻ **ECG Changes**
- ◻ **Pre-operative assessment**
- ◻ **Recent hospital admission for cardiac reasons**

Please tick any Previous History:

- ◻ **Coronary artery disease**
- ◻ **Previous Stents**
- ◻ **Coronary artery bypass surgery**
- ◻ **Valvular Heart Disease**
- ◻ **Diabetes**
- ◻ **Hypertension**
- ◻ **High cholesterol**
- ◻ **Atrial fibrillation/flutter**
- ◻ **Supraventricular tachycardia (SVT)**
- ◻ **Pacemaker/Defibrillator**
- ◻ **Alcohol Yes / No**

MEDICATION LIST:

ALLERGIES:

SMOKING HISTORY: ____

FAMILY HISTORY:

PAST HISTORY:

REASON FOR REFERRAL:

PLEASE ATTACH A COPY OF RECENT BLOOD TESTS AND ANY PRIOR CARDIAC INVESTIGATIONS TO THIS REFERRAL

REFERRER DETAILS

Referrer Name: ____________________________ Signature: ____________________________

Provider Number: __________________________ Date: _________________________________

**** Please email/fax us a copy of this referral in order to get an appointment.**
https://cardiacandvasculardiagnostics.com.au/