Charles Clinic

# CARDIOLOGY REFERRAL

Patient's Name:
Address:
DOB:
Phone: Mobile:

**Please perform the following:**

- ☐ Consultation
- ☐ Consult / investigations if required
- ☐ Echocardiogram
- ☐ Exercise Stress Echo
- ☐ Ambulatory Blood Pressure Monitor
- ☐ ECG
- ☐ Exercise Stress Test
- ☐ Holter Monitor
- ☐ Dobutamine Stress Echo
- ☐ Other *(specify)*

**Clinical History** - (Please include previous cardiac related operative reports, medications and any special requirements e.g. reduced mobility etc.)

**Medication List**

**Referring Doctor**:
Address:
Phone: Fax:
Email: Signature:
Date: Provider No. Copy to:

**Charles Clinic Heart Care** 110/287 Charles Street, Launceston TAS 7250
P: 03 6311 1555 F: 03 6334 2424 www.charlesheart.care
Charles Clinic Heart Care prefers to use HealthLink for secure messaging of patient data. Our **EDI** is **heartctr**
"Together we lead the way with committed compassionate care"