Tas Holters

Holter Referral

Patient Name: _____

DOB: ____ / ____ / ____ Gender: _____

Address: _____

_____

Phone: _____ Mobile: _____

Please perform the following:

- ☐ Holter Monitor
- ☐ Cardiology consultation if test indicates

Clinical Indications

- ☐ Arrhythmia
- ☐ Assess heart rate
- ☐ Assess ectopic burden
- ☐ Atrial fibrillation
- ☐ Dyspnoea
- ☐ Palpitations
- ☐ Syncope
- ☐ TIA/CVA

Other: _____

_____

_____

Additional Clinical Notes _____

_____

_____

_____

Referring Doctor: _____

Practice: _____

Address: _____

Phone: _____ Fax: _____

Provider No: _____

Signature: _____ Date: ____ / ____ / 20____

Copy To: _____

Please forward referral to: **Fax:** 03 6334 2424 **HealthlinkEDI:** Heartctr

Email: office@tasholters.com.au

Tas Holters 107/287 Charles Street, Launceston TAS 7250 **Ph**: 03 6311 1404