

Cardiac Education Referral Form

Referral Date: ____ / ____ / ____

Referred From: RDH/PRH ASH DPH GP Other: _____

Patient Details: Date of birth: ____ / ____ / ____

Name: _____ Contact number: _____

Postal Address: _____

Suburb/Community: _____ State: _____ Postcode: _____

Principal Diagnosis:

ACS Angina STEMI NSTEMI Heart Failure Arrhythmia
 Other (please specify): _____

Details: _____

Treatments/Procedures (include date and results):

PCI(Stent):

Angiogram:

PPM/ICD:

CABGS:

Valve-AVR/MVR/TVR/TAVI:

Relevant Past History:

Recent Investigations:

Lipids Date: _____ TC: _____ HDL: _____ LDL: _____ Trig: _____

Echo Date: _____ EF %: _____ Hba1c Date: _____ Hba1c Results: _____%

Blood Pressure: _____ Troponin: _____

Medication List:

Special Requests/Physical Activity Limitations:

Interpreter Required: Yes No Language Required: _____

Referrer Name: _____ Designation/Position: _____

Signature: _____

Please send referral via fax: **08 8927 8515** or via HealthLink EDI: **healthnt**