Streamlined GP access to cardiac CT for the investigation of angina

Referring Doctor Details:

Name:

Provider number:

Referral date:

Address for correspondence:

Telephone:

Fax:

Signature:

Patient Details:

Name:

Address:

Telephone:

Medicare number:

Pension or health care card number (if applicable):

Referral details:

- Chest pain: Yes / No
- Breathlessness (angina equivalent): Yes / No
- Other:

Cardiac Risk Factors (tick all that apply):

- ☐ HT
- ☐ Hypercholesterolaemia
- ☐ Smoking (delete as applicable):
  - Current / Ex-smoker / Never Smoked
- ☐ Diabetes
- ☐ Family History of Ischaemic Heart Disease

Cardiology review requested for discussion of results:

- ☐ Face to face
- ☐ Telephone or telehealth review

Please send completed form to Melbourne Heart Group:

Fax: 9500 1464

Email: reception@melbourneheart.com.au