



# GIPPSLAND CARDIOLOGY SERVICE

Ph: (03) 5132 1323  
Fax: (03) 4104 0882  
E: [info@gippslandcardiology.com.au](mailto:info@gippslandcardiology.com.au)  
W: [www.gippslandcardiology.com.au](http://www.gippslandcardiology.com.au)

Suite 1, Maryvale Health Care Centre  
Maryvale Private Hospital  
286 Maryvale Road  
Morwell VIC 3840

## Patient Referral Form

In-patient    Out-patient    Urgent

### Test(s) Required *(Please select one of the MBS criteria for echocardiogram or stress echocardiogram)*

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Cardiology consultation<br><input type="checkbox"/> Pacemaker/ICD Check<br><input type="checkbox"/> 12 lead ECG<br><input type="checkbox"/> Holter monitor<br><input type="checkbox"/> Exercise ECG | <input type="checkbox"/> <b>Echocardiogram:</b><br><input type="radio"/> Heart failure<br><input type="radio"/> Left ventricular hypertrophy<br><input type="radio"/> Valvular heart disease<br><input type="radio"/> Aortic valve disease<br><input type="radio"/> Pericardium<br><input type="radio"/> Cardiac mass<br><input type="radio"/> Congenital heart disease<br><input type="radio"/> Surveillance of known heart failure or valvular lesion<br><input type="radio"/> Other – please specify below | <input type="checkbox"/> <b>Stress echocardiogram:</b><br><input type="radio"/> Chest pain (with or without history of IHD)<br><input type="radio"/> Abnormal ECG without known CAD<br><input type="radio"/> Exertional dyspnoea<br><input type="radio"/> Silent ischaemia suspected/unable to be excluded<br><input type="radio"/> Valvular heart disease (severe AS or significant AR/MS)<br><input type="radio"/> Other—please specify below |
|--|---|---|

**All diagnostic tests are bulk billed. Minimum age for diagnostic test is 17yo.**

### Patient Details:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Medicare No.: \_\_\_\_\_

### Clinical Details:

### Referring Doctor's Details:

Dr: \_\_\_\_\_ Signature: \_\_\_\_\_

Clinic Details: \_\_\_\_\_

Date of referral:     /     /     Provider No.: \_\_\_\_\_

CC: \_\_\_\_\_ CC:  MVPH Medical Records

\_\_\_\_\_

\_\_\_\_\_