PATIENT REFERRAL

WINDSOR HEART
& SPECIALIST CENTRE

Referral to

Patient name

Date of birth ☐ Male ☐ Female

Address

Phone

Medicare number

Period of referral ☐ 3 months ☐ 12 months ☐ Indefinite

CLINICAL DETAILS

REFERRING DOCTOR

Referring doctors name

Provider number

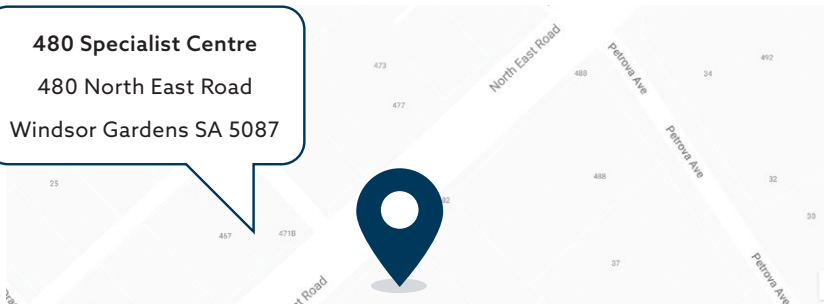
Address

REFERRAL FOR (TICK AS APPROPRIATE)

- ☐ Consultation
- ☐ ECG
- ☐ Ambulatory BP monitor
- ☐ Exercise stress test (treadmill)
- ☐ Exercise stress echo
- ☐ Echocardiogram
- ☐ Holter monitor (24 hr - discuss if longer duration required)

SIGNATURE _____ **DATE**

480 Specialist Centre
480 North East Road
Windsor Gardens SA 5087



PLEASE SEND REFERRAL TO

practice.manager@windsorheart.com.au

ALL OTHER ENQUIRIES

Clinic 08 7092 2760

Fax 08 8166 3362

www.windsorheart.com.au