

REFERRAL FORM

Patient Details

First Name _____
 Last Name _____
 Address _____
 DOB _____
 Home Phone _____ Mobile _____

Clinical Details Please provide list of latest medications and recent investigations if possible

Services Requested

- Cardiac Consultation
- ECG
- Echocardiography
- Stress Echo/Stress ECG
- 24hr ABP Monitor
- Holter Monitor

Referrer Details

Name _____
 Address _____
 Phone No: _____ Fax No: _____
 Provider No: _____
 Signature _____ Date _____
 GP Name (If not referrer) _____

Appointment Details

Date _____
 Time _____

Address

Suite 401 RPAH Medical Centre
 100 Carillon Avenue Newtown NSW 2042

Requested Doctor

- Prof Raj Puranik FRACP PhD SCMRIII
- Dr Alla Waldman FRACP PhD
- Prof Anthony Keech FRACP FCSANZ FAHMS
- Dr Alice Tiong FRACP PhD
- A/Prof Michael Kilborn FRACP FCSANZ FACC DPhil
- Prof Martin Ng FRACP PhD
- A/Prof Mark Dennis FRACP PhD DDU SCMRIII
- Dr Yasith Kamaladasa MBBS MMed FRACP

