0491 215 002
02 9475 0428
referrals@sydneyheartteam.com.au
www.sydneyheartteam.com.au

CLINIC REFERRAL FORM

SYDNEY HEART TEAM

PATIENT DETAILS

First Name: _____ Last Name: _____ DOB: D D M M Y Y Y Y

Street Address: _____

Suburb: _____ Postcode: _____

Phone: _____ Email: _____

Medicare Number: _____ Ref: _____ Valid until: M M Y Y Y Y

◯ Pension / DVA: _____ ◯ Health Fund: _____

Membership / Claim Number: _____

◯ Primary Language Spoken: _____ ◯ Interpretor Recommended

Renal Impairment: ◯ YES ◯ NO ◯ UNKNOWN	Diabetes: ◯ YES ◯ NO ◯ UNKNOWN

REFERRING DOCTOR

Referring Doctor: _____ Phone: _____

Email: (Direct email, not practice) _____

Doctor's Signature: _____ **Date:** _____ **Provider Number:** _____

REASON FOR REFERRAL

(PLEASE LIST BELOW)

◯ Valvular heart disease (aortic, mitral, tricuspid, other)
◯ Coronary artery disease (macrovascular, microvascular, vaspospastic, other)
◯ OTHER

_____

_____

_____

_____

Include current medications, attach latest correspondence, relevant imaging reports, cardiac surgical reports and pathology (if applicable).

_____

_____