

OTWAY HEART REQUEST FORM

www.otwayheart.com.au

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Please Fax or email referrals to admin@otwayheart.com.au or Fax: 03 8677 3335

Patient Name:	Date of Birth:
Patient Address:	Medicare Number:
Mobile/Home Phone:	Patient consent (office use):

<input type="checkbox"/> Echocardiogram Initial Echo: MBS item 55126	<input type="checkbox"/> Symptoms or signs of heart failure (e.g. shortness of breath, ankle swelling, etc) <input type="checkbox"/> Ventricular dysfunction (suspected) <input type="checkbox"/> Ventricular dysfunction (known) <input type="checkbox"/> Ventricular hypertrophy (suspected) <input type="checkbox"/> Ventricular hypertrophy (known) <input type="checkbox"/> Congenital heart disease/heart tumour	<input type="checkbox"/> Valvular heart disease (Murmur FI) <input type="checkbox"/> Aortic disease <input type="checkbox"/> Pericardial disease <input type="checkbox"/> Stroke or thromboembolism
<input type="checkbox"/> Echocardiogram Serial Echo: MBS item 55128	<input type="checkbox"/> Known primary valvular heart disease as per management guidelines	
<input type="checkbox"/> Echocardiogram Serial Echo: MBS item 55133	<input type="checkbox"/> Pericardial effusion or pericarditis	<input type="checkbox"/> Cardiotoxic medications as per PBS requirement
<input type="checkbox"/> Stress Echo Test (Treadmill) MBS item 55141	<input type="checkbox"/> Typical or atypical angina <input type="checkbox"/> Exertional unknown etiology <input type="checkbox"/> Known coronary artery disease with evolved symptoms <input type="checkbox"/> Abnormal ECG without known history <input type="checkbox"/> Abnormal calcium score or cardiac CT <input type="checkbox"/> Silent ischemia is suspected <input type="checkbox"/> Prior to valvular intervention	<input type="checkbox"/> Pre-op assessment with reduced exercise capacity (<4METS) and with at least two of: heart failure, ischaemic heart disease, stroke/TIA, eGFR<60, or diabetes on insulin

<input type="checkbox"/> 12-lead ECG + report MBS item 11704
<input type="checkbox"/> 24 Hour Holter monitor MBS item 11716

Clinical notes:

Referrer Details: Provider Number: Doctor's Signature:	Date:	Copies to:
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Locations:

28 Hart St. **COLAC:** 14 Hospital Rd. **TIMBOON:** 230 Mountjoy Pde. **LORNE** 30 Villers St. **PORT FAIRY**