Otway Heart
CARDIOLOGY SERVICES

OTWAY HEART REQUEST FORM

www.otwayheart.com.au
Ph: 0474 771 927

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):**

☐ Echocardiogram Initial Echo: MBS item 55126	☐ Symptoms or signs of heart failure (e.g. shortness of breath, ankle swelling, etc) ☐ Ventricular dysfunction (suspected) ☐ Ventricular dysfunction (known) ☐ Ventricular hypertrophy (suspected) ☐ Ventricular hypertrophy (known) ☐ Congenital heart disease/heart tumour	☐ Valvular heart disease (Murmur FI) ☐ Aortic disease ☐ Pericardial disease ☐ Stroke or thromboembolism
☐ Echocardiogram Serial Echo: MBS item 55128	☐ Known primary valvular heart disease as per management guidelines	
☐ Echocardiogram Serial Echo: MBS item 55133	☐ Pericardial effusion or pericarditis	☐ Cardiotoxic medications as per PBS requirement
☐ Stress Echo Test (Treadmill) MBS item 55141	☐ Typical or atypical angina ☐ Exertional unknown etiology ☐ Known coronary artery disease with evolved symptoms ☐ Abnormal ECG without known history ☐ Abnormal calcium score or cardiac CT ☐ Silent ischemia is suspected ☐ Prior to valvular intervention	☐ 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
☐ 12-lead ECG + report MBS item 11704 ☐ 24 Hour Holter monitor MBS item 11716		
Clinical notes:		
Referrer Details: ***Provider Number:*** ***Doctor's Signature:*** ***Date:***		***Copies to:***

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