

Structural Heart Disease Clinic Referral Form

Identify Patient and Requester

Patient Details/Bradma

Patient Name: Date of Birth:

Monash Health UR Number:

Address:

Home Number: Mobile Number:

Email:

Requester Details

Referring Dr: Signature: Date:

Provider No: Pager No: Phone Nos:

Address:

Copy of Report/Letters to: 1.

2.

Situation Relevant clinical details

ASD/PFO Aortic Stenosis/Regurgitation Mitral Stenosis/Regurgitation Hypertrophic Obstructive CardioMyopathy

Patent Ductus Arteriosus Aortic Coarctation Tricuspid Stenosis/Regurgitation Pulmonary Stenosis/Regurgitation

VSD Other

Further Clinical Details

Background Background of Known Pathology (please provide all details of known heart disease)

Renal impairment, creatinine μ mol/l Diabetes Hypertension Previous PCI Previous CABGs

Most recent echocardiogram (date and location)

If possible please forward images of the most recent TTE and most recent consultation letter with this referral

Assessment

Request

Consultation at the Structural Heart Clinic


Tel: (03) 9594 4335
Fax: (03) 9594 6239
Email: structuralheart@monashhealth.org

To make an appointment, please fax this referral to 03 9594 6239 or scan and email to:
structuralheart@monashhealth.org.

Please note appointments cannot be made over the phone.



Monash Heart Structural Heart Disease Clinic is located at Suite D Monash Medical Centre.

 **MonashHeart Suite D**
Level 2, Monash Medical Centre
246 Clayton Road, Clayton 3168
www.monashheart.org.au

Office Use Only

Correct Patient (patient to state where possible their full name and D.O. B. and address).

Please tick 3 patient identifiers before commencing test:

Full Name D.O.B Address Wristband Ankleband