ADELAIDE HEART CLINIC

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- ☐ Dr Dale Ashby
- ☐ Dr Enzo De Angelis
- ☐ Prof Peter Psaltis
- ☐ Dr Ivan Straznicky
- ☐ Dr Richard Yeend
- ☐ Dr Joshua Lushington

REQUEST FOR CARDIOLOGY SERVICES

Patient Name: .....

Date of Birth: ...../...../..... Sex: .....

Medicare No: _ _ _ _ _ _ _ _ _ _ _ Ref No: _

- ☐ **Consultation**
- ☐ **Exercise Stress Test**
- ☐ **Echocardiogram**
- ☐ **24hr Ambulatory BP Monitor**
- ☐ **24hr Holter Monitor**
- ☐ **ECG Report**
- ☐ **Exercise Stress Echo**

CLINICAL DETAILS:

Signature: .....

Referring Doctor: .....

Provider No: .....

PH: ( ) ..... FAX: ( ) .....

I consent to having the above investigations: .....

APPOINTMENT DETAILS: .....

REFERRAL REQUIRED ☐ YES ☐ NO

Location:

☐ Adelaide Heart Clinic
32 North Terrace
KENT TOWN SA 5067

☐ Calvary Adelaide Hospital
Level 2/120 Angas Street
ADELAIDE SA 5000