LifePulse
CARDIOLOGY

CARDIOLOGY REQUEST/REFERRAL FORM

PATIENT DETAILS

First Name: _____ Last Name: _____

Birth Date: _____ Address: _____

Email: _____ Phone No: _____

Medicare Number: _____

CONSULTATION

◯ Dr Aleksandra Lange ◯ Dr Przemek Palka ◯ First Available Cardiologist

APPOINTMENT URGENCY

◯ Urgent Appointment (Within 24 Hours) ◯ First Available Appointment

TEST REQUEST

◯ Ambulatory ECG / Holter Monitoring
◯ Transthoracic Echocardiogram (TTE)
◯ Exercise Stress Echocardiogram (ESE)
◯ Exercise Stress Test
◯ Cardiac CT (consultation required)
◯ TOE Guided DC Cardioversion

SPECIALIST CLINIC / CONSULTATION

◯ Cardio-oncology Specialised Cardiac Clinic
◯ Heart Failure Specialised Cardiac Clinic
◯ POTS Specialised Cardiac Clinic

CLINICAL DETAILS *(note below):*

REFERRING DOCTOR DETAILS

First Name: _____ Last Name: _____

Practice Name: _____ Provider Number: _____

_____ _____

Referring Doctor Signature Date

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