Peninsula Health

REFERRAL TO REDUCED EJECTION FRACTION CLINIC

UR NUMBER ..... D.O.B .....

Surname..... Given Name .....

Address .....

Post Code ..... Phone ..... Gender .....

Please fill in if no Patient Label available

App.20/6/17 Print Code:14521

PHF054750n

Patient's second contact / mobile number: .....

Is the patient within one of the following compensable categories?

☐ Workcover ☐ T.A.C. ☐ D.V.A. ☐ Overseas visitor (ineligible for Medicare)

Referrer Details:

Name of Referring Dr (print): ..... Date of Referral: ...../...../.....

Signature: ..... Phone No: .....

Provider Number (mandatory): .....

Referrals without a valid Medicare provider number from the referring doctor cannot be processed

Reason for Referral: .....

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LVEF on Echo or Nuclear scanning ☐ %

(Failure to provide will result in the patient not being booked)

Please fax completed referral and any relevant investigation reports to: 9784 2387

OUTPATIENT OFFICE USE ONLY

Received on:...../...../..... Triaged by: .....

Clinic required:..... Date:...../...../.....

Clinic appointment booked: Date..... /...../..... Time .....

Patient notified by: ☐ Phone ☐ Mail Notified & Processed by: .....

Comments: .....

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MR/054750

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