ASHFORD
CARDIAC CLINIC

REFERRAL FOR CARDIAC SERVICES

TO DOCTOR

PATIENT NAME | DOB | | |

ADDRESS

PERIOD OF REFERRAL (MONTHS) ◯ 3 ◯ 6 ◯ 12 ◯ INDEFINITE | MEDICARE NUMBER

REASON FOR REFERRAL

- ◯ 1. CARDIOLOGY CONSULTATION
- ◯ 2. ECHOCARDIOGRAPHY
- ◯ 3. BLOOD PRESSURE MONITORING
- ◯ 4. HOLTER MONITOR (24HR ECG)
- ◯ 5. 12 LEAD ECG WITH REPORT
- ◯ 6. REPORT ON ECG
- ◯ 7. EXERCISE STRESS ECHOCARDIOGRAM
- ◯ 8. DOBUTAMINE STRESS ECHOCARDIOGRAM

REPORT TO BY SENT BY ◯ MAIL OR ◯ FAX TO:

REFERRING DOCTOR

PROVIDER NUMBER | TELEPHONE | FACSIMILE

ADDRESS

SIGNATURE | DATE | | |

Dr Sam Lehman | Dr Cameron Singleton | Dr Andrew Markwick
Dr Fahd Chahadi | Dr Suchi Grover | Dr Ranjit Shah | Dr Andrew Russell

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This form may be used for the provider of your choice