



Adel Heart

Dr. Alexander Adel (MBBS, FRACP)
& Associates

CARDIOLOGY REFERRAL

Patient Name _____

Gender M F D.O.B. _____ (17 years or older)

Address _____

Phone No. _____ Medicare No. _____

Appointment time : _____ Date _____ / _____ / _____

- Consultation
- Exercise Stress Echo
(Non-specialist referrers: 2-year interval restriction applies. Consultation recommended if further assessment anticipated)
- Echocardiogram
(Non-specialist referrers: 2-year interval restriction applies. Consultation recommended if further assessment anticipated)
- Holter Monitor 24 hour
- ECG
- BP Monitor 24 hour

Main Rooms

Malvern East

Malvern Heart Centre
389 Wattletree Rd. Malvern E., 3145
Ph: 9132 9832 Fax: 9132 9840
admin@adelheart.com.au

Footscray

Heartcare Footscray
54 Eleanor Street, Footscray, 3011
Ph: 9317 3466 Fax: 9318 4312

REFERRAL & CLINICAL NOTES

Hoppers Crossing

755 Sayers Rd. Hop's Crossing, 3019
Ph: 8754 7600 Fax: 8754 7699

Whittlesea

Whittlesea Family Medical Centre
4 Mackmeikan St. Whittlesea, 3757
Ph: 9716 0153 Fax: 9716 0156

Relevant Medications:

Consultation referral valid for 12 months unless otherwise stated

Port Melbourne

Prowellness Health Centre
3/120 Bay St. Port Melbourne, 3207
Ph: 9676 8888 Fax: 9676 9922

REFERRING DOCTOR – Please Sign and Date

Name _____ Provider No. _____

Address _____ Phone No. _____

_____ Fax No. _____

Signature _____ Date _____

Copies to _____

Ringwood

Dr Dinesh Natarajan
Maroondah Specialist Group
9 Ware Cres. Ringwood East, 3135
Ph: 9870 5988 Fax: 9879 2101

Keysborough

Dr Rifly Rafiudeen
Keys Medical Centre
1/211 Chapel Rd. Keysborough 3173
Ph: 8759 3807

See overleaf for further information and consent form

OFFICE USE ONLY – Initials: _____ Date: _____ / _____ / 20_____

HPOS eligibility Y N Indication valid Y N Consent Y Item No. 55126 55127 55129 55133 55134 55141 55143
24/12 VHD HF/SHD PE Other 24/12 12/12

Information and Consent Form

Patient Name _____ D.O.B. _____
Address _____

ECHOCARDIOGRAM & EXERCISE STRESS TEST

An Echocardiogram is an ultrasound scan of your heart. This involves the application of ultrasound gel and probe to the chest. There is no radiation. Cables are also attached to the chest to capture the rhythm of the heart.

This test is often combined with an "Exercise Stress Test" to assess heart function during exercise, where you will be supervised while walking/running on a treadmill. Your heart rate and blood pressure usually increase during this test.

The purpose of the tests is to provide important information about the structure of your heart and may detect abnormalities of blood flow to the heart.

You will be asked to expose your chest to allow for scanning of the heart and attachment of the ECG cables. A privacy gown is provided for all female patients.

COMPLICATIONS & RISKS:

The tests are generally very safe, with very low risk of complications.

Common side-effects:

Dizziness, Joint Pain, Chest Discomfort and Shortness of Breath are common during the exercise test.

Rare events (1 in 1000):

Rhythm abnormalities of the heart may develop during exercise. If this occurs, it will often normalize, though occasionally you may need additional treatment, and possibly hospital admission.

Asthma attacks may occur during exercise test.

Extremely rare events: There is an extremely small risk of a heart attack (1 in 2000) or death (1 in 10000)

HOLTER MONITORING

An Holter Monitor is a 24 hour recording of the rhythm of your heart. A recorder with three to five cables is attached to the chest. If you have any symptoms during the test, you may activate the "event" button on the front of the recorder. Please take care not to expose the recorder and cables to liquids.

YOU MUST INFORM US OF THE FOLLOWING:

- If there is any limitation to your exercise capability
- You have had or are experiencing chest pains on the day of the test
- You have a viral infection/skin infection that may pose a risk to others
- Any questions you would like addressed prior to commencing the test

CONSENT:

I consent to the performance of above test(s). I understand what the test consists of, their potential complications, and that the test result may be an indicator of a potential medical abnormality and does not constitute a complete medical exam on which I can rely. To understand the result of the test(s), and to obtain a diagnosis of a medical problem, I must see a physician for a complete medical exam.

Signature: _____ Date: _____