Dr Kyi Win (Cardiologist)
South Eastern Heartcare

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REFERRAL

Patient Name _____ DOB ____ / ____ / ____

Contact Number _____

Address _____

Services Requested

- ☐ Cardiologist consultation (Please attach a referral letter)
- ☐ 24 hour holter monitoring **(Bulk-billed)**
- ☐ ECG
- ☐ Echocardiogram **(Bulk-Billed)**
- ☐ Exercise Stress Echocardiogram including consultation and opinion **(Bulk-billed)**

OR ☐ Exercise Stress Echo only

MBS rebate criteria for stress Echo must be met for bulk-billing. Please tick ONE below

- ☐ Typical or Atypical anginal symptoms
- ☐ ECG changes consistent with CAD without a known coronary heart disease
- ☐ Undue Exertional shortness of breath of uncertain aetiology
- ☐ Suspected silent ischemia in patients with cognitive/communication difficulties
- ☐ To assess ischemia on the CAD identified on CTCA or Angiogram
- ☐ Cardiologist referral to assist with a diagnosis for the patient with a **potential non-coronary artery disease**
- ☐ Preoperative assessment for patients with elevated cardiac risk and reduced functional capacity (<4METS) going for intermediate-risk surgery
- ☐ Patients with a significant valvular heart disease to assist with management decision

Clinical History _____

Referring Doctor _____ Date ____ / ____ / ____

Provider Number _____ Phone _____

Address _____ Fax _____

Signature _____

For all appointments and inquiries, please call (03) 7034 4707