**Genetic Cardiac Referral Form**

**Patient details (please affix patient sticker where possible):**

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| --- | --- |
| URN: | DOB: |
| Surname: | First name: |
| Maiden or other name: |  |
| Address: | |
| Mobile: | Medicare number: |
| Email: | |
| Interpreter required: Yes / No | Language: |

**Reason/s for referral:**

|  |  |
| --- | --- |
| Appointment:  🞏 Urgent: within 2 weeks  🞏 Priority: 6 – 8 weeks  🞏 Non-urgent: 8 – 12 weeks | 🞏 Adult genetic testing and/or diagnosis  🞏 Abnormal genetic test result  🞏 Preconception or pregnancy counselling  If pregnant, EDD: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  🞏 Other (please specify): |
| **Details:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Please include additional information below. | |

**All relevant results/correspondence must be attached for referral to be triaged:**

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| 🞏 Relevant imaging reports (MRI, ECG, Echocardiogram) |
| 🞏 Relevant specialist consultation letters |
| 🞏 Other, (please specify): |

**Referring doctor:**

|  |  |
| --- | --- |
| Name (please stamp/print clearly): | Signature: |
| Practice/hospital: |
| Address: |
| Contact number/fax/email: |

**Family member/s with a known genetic condition or seen by a Genetic clinic:**

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| --- | --- |
| URN: | DOB: |
| Surname: | First name: |
| Genetic Service: | Condition: |

**Further Information:**

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