**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 counsellingIf 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:**

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

**Further Information:**

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