

Please email this referral to: info@drsophiawong.com or fax (02) 9058 8195

PATIENT DETAILS

First Name *	Last Name *	Date of Birth *
<input type="text"/>	<input type="text"/>	<input type="text"/>

Home Phone	Mobile	Email
<input type="text"/>	<input type="text"/>	<input type="text"/>

Address

Preferred clinic	Preferred time
<input type="checkbox"/> Bondi Junction	<input type="checkbox"/> Morning appointment
<input type="checkbox"/> Burwood	<input type="checkbox"/> Afternoon appointment
<input type="checkbox"/> Canley Vale	<input type="checkbox"/> Please specify: _____
<input type="checkbox"/> North Sydney	
<input type="checkbox"/> Telehealth	
<input type="checkbox"/> No preference	

Referral for comprehensive cardiac assessment, noting:

- Autonomic / POTS assessment
- Cardiovascular risk assessment and Preventative Care
- No consultation required (investigations only)

Investigations:

- Transthoracic echocardiography
- Exercise stress echocardiogram
- Dobutamine stress echocardiogram
- Holter Monitoring
- ECG
- Calcium score / CTCA

Additional Details:

REFERRING DOCTOR'S DETAILS

First Name *	Last Name *	Date of Referral *
<input type="text"/>	<input type="text"/>	<input type="text"/>

Provider Number *	Practice Address *
<input type="text"/>	<input type="text"/>

Your Signature *