



Cardiac CT Referral Form

Patient Details

Surnames

Given Names

DOB

Email

Address

Clinical Indicators & Relevant History

Phone / Mobile Number

Medicare Number

WorkCover Claim Number

Examination Requested

CTCA Please select indications below:

- CT Coronary Angiogram
- CT Coronary Calcium Score
- Chest pain or discomfort
- Coronary Artery Disease
- Abnormal or inconclusive stress test
- Pre-operative assessment (cardiac risk evaluation)
- Follow-up after stent or bypass surgery
- Strong family history of early heart disease
- CTLA
- Other Studies _____

Recent renal function within last three (3) months required for booking a CTCA (not required for CAC only).

Creatinine: _____ Date: _____

eFGR/CrCl: _____ Date: _____

Medical History

- | | |
|--|---|
| <input type="checkbox"/> Prior myocardial infarct | <input type="checkbox"/> Currently taking ACE inhibitor |
| <input type="checkbox"/> Prior coronary stent/angioplasty | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Coronary bypass graft | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Heart failure | <input type="checkbox"/> Renal impairment |
| <input type="checkbox"/> Currently on beta-blockers/
anti-arrhythmics | <input type="checkbox"/> Myeloma |

Medical History

Specialist Referral (Medicare eligible)

One of the following criteria must be present: Please select indications below:

- Patient has stable symptoms consistent with coronary ischaemia, is at low to intermediate risk of coronary artery disease and would have been considered for invasive coronary angiography.
- Patient requires exclusion of coronary artery anomaly or fistula.
- Evaluation of coronary arteries prior to non-coronary cardiac surgery.

Referring Doctor Details

Doctor Name:

Provider Number:

Address:

Phone:

Signature:

Fax:

Send Copy To:

Date: