SMARTCARE Diagnostics

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Springfield Central
Shop 8,
95 Southern Cross Cct,
Springfield Central
QLD 4300

Cardiac CT Referral Form

Patient Details

Surnames

Given Names

DOB

Email

Address

Phone / Mobile Number

Medicare Number

WorkCover Claim Number

Clinical Indicators & Relevant History

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

- ☐ Prior myocardial infarct
- ☐ Prior coronary stent/angioplasty
- ☐ Coronary bypass graft
- ☐ Heart failure
- ☐ Currently on beta-blockers/ anti-arrhythmics
- ☐ Currently taking ACE inhibitor
- ☐ Pacemaker
- ☐ Diabetes
- ☐ Renal impairment
- ☐ 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:

Fax:

Signature:

Date:

Send Copy To: