REQUEST FORM

PATIENT DETAILS

Name: ____________________________

DOB: _____________________________

Phone: ___________________________

TEST DETAILS

☐ Clinical Consultation
☐ 12 lead ECG
☐ Echocardiogram
☐ Exercise Stress Test
☐ Exercise Stress Echo
☐ Holter Monitor
☐ 7-Day Event Monitor
☐ Blood Pressure Monitor (24 hours)
☐ Ankle Brachial Index
☐ Other (additional options next page)

CLINICAL DETAILS

___________________________________________________________________________________________

___________________________________________________________________________________________

___________________________________________________________________________________________

REFERRING DOCTOR

Name: ____________________________ Date: __________________

Signature: _________________________ Provider Number: _________________________

Address: ___________________________
If your request is for
Exercise Stress Test or Exercise Stress Echo
DO NOT smoke or eat 2 hours prior to your test and refrain from tea, coffee, coca cola on the day of your test. Please ensure that your referring doctor and the doctor performing the test are aware of your medications. Wear comfortable clothes and shoes you can walk and exercise in.

Ipswich Cardiac Centre
33 Thorn Street, Ipswich, QLD 4305
Phone: (07) 3282 8333
Fax: (07) 3282 9444
www.ipswichcardiaccentre.com.au

Please contact us for other services including:

- Coronary Angiography
- Coronary Stenting & Angioplasty
- Cardiac Catheterisation
- Dobutamine Stress Echo (DSE)
- Transoesophageal Echo (TOE)
- Electrical Cardioversion
- Cardiac Electrophysiology
- Arrhythmia Ablation
- Implantable Loop Recorders
- Pacemakers & Defibrillators

Corner of Thorn Street and South Street