372 Magill Road, Kensington Park SA 5068
T: 8317 5300 **F:** 8317 5190
E: admin@integralhealthcare.com.au
W: integralhealthcare.com.au

To Doctor (BLOCK letters) ______________________________
[MANDATORY FOR CONSULTATION REFERRAL]

Patient Name (BLOCK letters) ______________________________

Address ______________________________

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DOB ____________________ Phone ____________________

Medicare number ____________________ ◯ Male ◯ Female

Period of referral ◯ 3 months ◯ 12 months ◯ Indefinite

Clinical Details (Please include medications)

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FOR THIS REFERRAL TO BE VALID THE FOLLOWING MUST BE COMPLETED:

Referring Doctor: ______________________________

Provider Number: ______________________________

Address: ______________________________

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Signature: ______________________________

Date: ______________________________

- ◯ **Consultation**
- ◯ **12 lead ECG**
- ◯ **Holter Monitor – 24 hour**
- ◯ **Holter Monitor – 2-7 day (please specify)**
- ◯ **Exercise Treadmill Stress Test**
- ◯ **Echocardiogram**
- ◯ **Stress echocardiogram**
- ◯ **Tilt Table Test**

For more information, please visit integralhealthcare.com.au