Heart of Canberra — Referral

DR KASHIF KALAM · MBBS, FRACP · CARDIOLOGIST · MULTIMODALITY CARDIAC IMAGING

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Email admin@heartofcanberra.com.au **Provider No.** 276481WA

PATIENT

FULL NAME _____ DATE OF BIRTH _____

ADDRESS _____ PHONE _____

MEDICARE NUMBER _____ REF _____ DVA / PENSION CARD (IF APPLICABLE) _____

REFERRAL

☐ Routine ☐ Urgent (urgent: please also phone the rooms)

REASON FOR REFERRAL / CLINICAL QUESTION

RELEVANT HISTORY, MEDICATIONS AND PRIOR INVESTIGATIONS (OR ATTACH SUMMARY)

REFERRING PRACTITIONER

NAME _____ PROVIDER NUMBER _____

PRACTICE _____ PHONE _____

SIGNATURE _____ DATE _____ REFERRAL PERIOD ☐ 12 months ☐ Indefinite

Send by HealthLink (hayescar), fax 02 6162 2742, or email admin@heartofcanberra.com.au. Consulting Monday to Friday, 9:00 am – 4:00 pm. This form is for referrals to Dr Kashif Kalam, Heart of Canberra, Deakin ACT. In an emergency call 000.