

Please complete and email to: webbookings@qscan.com.au
OR upload securely to our website: qscan.com.au/bookings

Patient name: _____

Birth date: _____

Address: _____

Phone: _____ Mobile: _____

WorkCover claim number: _____

EXAMINATION REQUESTED

- | | | |
|--|---|---|
| <input type="checkbox"/> CT coronary angiogram | <input type="checkbox"/> MRI cardiac | <input type="checkbox"/> Carotid doppler |
| <input type="checkbox"/> CT coronary calcium score | <input type="checkbox"/> Other studies | <input type="checkbox"/> CTLA |
| | <input type="checkbox"/> Echocardiogram | <input type="checkbox"/> Cardiac perfusion |
| | | <input type="checkbox"/> MIBI <input type="checkbox"/> Others |

CLINICAL DETAILS/REGION TO BE EXAMINED

REFERRAL ELIGIBILITY

SPECIALIST REFERRAL (Medicare eligible)

One of the following criteria must be present (please tick where appropriate):

CT (BULK BILLED)

- 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.

MRI (BULK BILLED*)

- | | |
|--|---|
| <input type="checkbox"/> Congenital cardiac | <input type="checkbox"/> ARVC/ARVD findings/symptom assessment - exclude arrhythmogenic right ventricular cardiomyopathy: right and left ventricular analysis will be performed |
| <input type="checkbox"/> Cardiac tumour | |
| <input type="checkbox"/> Thoracic aorta abnormality | |
| <input type="checkbox"/> First degree relative with confirmed ARVC | |

MRI

- (Non Medicare eligible)**
- Function and viability
- Hypertrophic cardiomyopathy
- Dilated cardiomyopathy
- Myocarditis or pericarditis (other causes)

*Some clinics and procedures may require a gap payment.
Any additional costs will be advised by the bookings team when placing an appointment.

REFERRING PRACTITIONER

Name: _____

Address: _____

Phone: _____

Fax: _____

Provider number: _____

Signature: _____

Date: _____

Send copy to: _____

Thank you for referring your patient to Qscan Radiology Clinics

Cardiac Referral



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

PLEASE TICK FOR PRINTED IMAGES



Qscan Radiology Clinics is committed to sustainability. All images are available digitally only unless requested.

IMAGES

- Online
- CD
- Return with patient
- Courier/Deliver

REPORT

- Electronic download
- Fax

MORE REFERRAL PADS

- A4 (computerised)
- A5 (manual)

Your doctor has recommended you attend Qscan Radiology Clinics. You may choose another provider but please discuss this with your doctor first.

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