



Royal Brisbane & Women's Hospital

QUEENSLAND CARDIAC GENETICS CLINIC REFERRAL FORM

(Affix patient identification label here)

URN:

Family Name:

Given Names:

Address:

Address:

Contact Number:

Medicare Number:

Date of Birth:

Sex: ☐ M ☐ F ☐ I

Please tick: ☐ Dr Julie McGaughran (Director)

Referral summary letters are also welcome.

Complete all sections, sign and fax to:

1300 364 952

(Metro North Central Patient Intake Unit)

For urgent referrals or clinical queries please contact the on-call team: 07 3646 1686

☐ Patient / family aware of referral

Speciality:

☐ Translator required

Consultant / GP Name:

Language:

Consultant / GP Provider Number:

☐ Urgent (*indication*):

Contact Number:

Address:

☐ Non-Urgent

Clinical information:

Diagnosis and relevant family history:

*Please include all
relevant investigations:*

- ECG
- ECHO/MRI
- Autopsy
results

*(demonstrating the
diagnostic features)*

Reason for referral:

Doctor's Name:

Designation:

Signature:

Date:

DO NOT WRITE IN THIS BINDING MARGIN

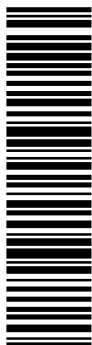
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All clinical form creation and amendments must be conducted through Health Information Services

MR 61402

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