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Queensland Government

**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<br>Language: | Consultant / GP Name:<br>Consultant / GP Provider Number: |
| ☐ Urgent *(indication)*:<br><br>☐ Non-Urgent | Contact Number:<br>Address: |

**Clinical information:**

| Diagnosis and relevant family history: | *Please include all relevant investigations:* |
|---|---|
| | - *ECG*<br>- *ECHO/MRI*<br>- *Autopsy results*<br><br>*(demonstrating the diagnostic features)* |

Reason for referral:

| Doctor's Name: | Designation: | Signature: | Date: |
|---|---|---|---|
| | | | |



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