



Queensland Government

Royal Brisbane and Women's Hospital

GENETIC HEALTH QUEENSLAND (GHQ) CARDIAC GENETICS CLINIC REFERRAL

(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: 1300 447 753**

This referral form is not a pathology request form and cannot be used to organise testing through a private pathology laboratory.

Note: Prenatal Referrals: Have you included a separate referral for both patient and partner?

Child Referrals: Have you included a separate referral for both patient and parents?

All patients referred to GHQ must have a valid Medicare Card and be a resident of Queensland

Patient / family aware of referral

Speciality:

Interpreter 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

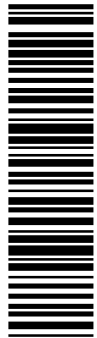
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All clinical form creation and amendments must be conducted through Health Information Services

MR 61402

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Locally Printed



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