HEART WELLNESS REQUEST FORM

THE MELBOURNE EASTERN PRIVATE HOSPITAL

FAX REFERRALS TO: (03) 9720 5047
OR CALL: (03) 9720 3388

157 Scoresby Road
Boronia VIC 3155

Referral Date:	☐ Inpatient ☐ Outpatient

PATIENT DETAILS:

Patient Name:	DOB:
Address:	Age:
Postcode:	Contact Number:

CLINICAL DETAILS: PLEASE TICK ONE BOX

- ☐ Reconditioning following a recent cardiac event where the patient is medically stable
- ☐ Reconditioning following a recent cardiac surgical intervention
- ☐ Reconditioning following an exacerbation of a chronic cardiac condition
- ☐ Patient is deconditioned as a result of cancer or following treatment from cancer
- ☐ Suffering a deterioration of functional ability following a recent or previous stroke

Patients Primary Heart Condition: *(please state)*

Please attach a copy of the patients medical history and if relevant any recent results from cardiac diagnostic tests with this request form

INSURANCE DETAILS:

Health Fund:	Member No:	
Medicare No:	Expiry:	
Pension Health Card No:		
DVA No:	Admitted as DVA: ☐ YES ☐ NO	Card: ☐ Gold ☐ White ☐ Orange

REFERRING DOCTOR DETAILS:

Doctor:	
Provider Number:	
Medical Practice:	
Signature:	