



## HCM Referral Form

\* Healthlink EDI: myheartc  
 www.myheartcardiology.com.au  
 referral@myheartcardiology.com.au

Suite 8.3, 89 Bridge Rd, Richmond VIC 3121  
 Tel: (03) 9854 6444  
 Fax: (03) 9854 6445

### Patient's details

Name:	Date of Birth:	Medicare Number:
Phone/Mobile:	Address:	

### Clinical Consultation

#### Clinical Consultation HCM / Inherited Cardiomyopathy

Clinical History:

#### HCM Referral Reason ( select all that apply ):

- |  |                                       |
|--|---------------------------------------|
| Known / confirmed HCM diagnosis                  | LVOT obstruction documented           |
| Family history of sudden cardiac death           | Advanced medical therapy (Mavacamten) |
| Suspected HCM / unexplained LVH on echo          | ICD assessment / device management    |
| Relative of known HCM patient – family screening | Septal reduction therapy assessment   |

### Diagnostic Studies

#### Transthoracic Echocardiogram (TTE) ( once every two years )

- |  |                                       |
|--|---------------------------------------|
| Symptoms or signs of cardiac failure                         | Congenital heart disease              |
| Ventricular hypertrophy or dysfunction                       | Sudden death of an immediate relative |
| Valvular, aortic, pericardial, thrombotic or embolic disease | Pulmonary hypertension                |
| Before starting drugs which require cardiac monitoring       | Employment medical - No MBS Rebate    |
| Heart tumour   |                                       |

#### Cardiac MRI + Consultation

##### Cardiac Device Checks

Pacemaker      Defibrillator (ICD)      S-ICD (Subcutaneous ICD)      Device's company if known: .....

#### 12 Lead ECG (trace and report)

#### Heart Rhythm Monitor (please choose duration)

1 Day                                      7 Days                                      Up to 28 Days

Indications:    Palpitations            Syncope            Arrhythmia            AF monitoring (HCM)            Post-ablation monitoring

### Referring Practitioner Details

Name:	Phone:
Provider Number:	Fax:
Address:	Signature: .....
Email:	