HCM Referral Form

My Heart Cardiology

Healthlink EDI: myheartc
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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
- ☐ Family history of sudden cardiac death
- ☐ Suspected HCM / unexplained LVH on echo
- ☐ Relative of known HCM patient – family screening
- ☐ LVOT obstruction documented
- ☐ Advanced medical therapy (Mavacamten)
- ☐ ICD assessment / device management
- ☐ Septal reduction therapy assessment

Diagnostic Studies

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

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

☐ 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:	