



Vascular Medicine Referral Form

- * Healthlink EDI: myheartc
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- Tel: (03) 9854 6444
- Fax: (03) 9854 6445

- Suite 8.3, 89 Bridge Rd, Richmond VIC 3121
- 147 Moreland Road, Coburg VIC 3058
- 38-40 Gap Rd, Sunbury VIC 3429
- 5 Neal Street, Gisborne VIC 3437
- 182 Station Rd, New Gisborne VIC 3438
- 89 Piper St, Kyneton VIC 3444

Patient's Details

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

Aortic/Genetic Risk Screening (tick if applicable)

- Aortic aneurysm, dilation, or dissection
- Aortic disease diagnosed before age 60
- Family history of aortic aneurysm, dissection, or sudden unexplained death (<60 years)
- Known or suspected connective tissue disorder (e.g. Marfan, Loeys-Dietz, Ehlers-Danlos)
- Multiple or unusual arterial aneurysms/dissections
- Previous or planned genetic testing
- Unexplained aortic dilation (no clear risk factors)

Current Medications

Please include all prescribed medications, OTC drugs, and supplements:

Symptoms (brief):

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Relevant Medical History:

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Please attach ALL available investigations:

- Echocardiogram
- Stress Test / Exercise ECG
- Holter Monitor Report

- Blood test results (FBE, Iron studies, lipids studies, HbA1C and any previous genetic tests, TSH, Cortisol, etc.)
- Imaging reports (e.g., CT, MRI)
- Any relevant specialist letters or documentation

Referring Practitioner Details

Name:	Phone:
Provider Number:	Date:
Clinic:	Signature:
Email:	