My Heart Cardiology

Vascular Medicine Referral Form

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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):

Relevant Medical History:

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:	