SEC
SYDNEY ECHO CLINIC

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HEALTHLINK EDI: sydechoc

Patient Name: _____ **Contact No:** _____

Address: _____ **DOB:** _____

Medicare No: _____

ECHOCARDIOGRAM REQUEST FORM

Type of request (tick eligible MBS criteria)	
Echocardiogram (55126) Initial study Requested by **ANY** medical practitioner including GP (Once every 24 months)	Investigation of: ☐ Symptoms or signs of cardiac failure ☐ Suspected or known LV hypertrophy or LV dysfunction ☐ Pulmonary HTN ☐ Valvular, aortic, pericardial, thrombotic or embolic disease ☐ Heart tumour ☐ Symptoms or signs of congenital heart disease ☐ Other rare indications* *e.g. sudden death of immediate relative, pre-commencement of specific drugs which require cardiac monitoring, or where scheduled for cardiac surgery and have not previously had an echocardiogram (non-exhaustive list of indications)
Echocardiogram (55133) Repeat studies Requested by **ANY** medical practitioner including GP	☐ Isolated pericardial effusion or pericarditis ☐ Monitoring of patients on medication with cardiotoxic side effects (must comply with PBS guidelines)
Echocardiogram (55127) Repeat study	**SPECIALIST ONLY** ☐ Known valvular dysfunction
Echocardiogram (55129) Repeat study	**SPECIALIST ONLY** ☐ Known non-valvular cardiac disease (structural heart disease)

Additional clinical notes:

Referring Doctor's Details

Name: _____ Provider No: _____

Address: _____

Phone or email: _____ Signature:

Date: _____

Report: ☐ Email: _____ ☐ HealthLink

☐ Fax: _____ ☐ Medical Objects