Cardiotest

CARDIAC INVESTIGATIONS

REFERRAL FORM

Holter / ambulatory blood pressure monitoring

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1 PATIENT DETAILS

Full name	Date of birth (DD/MM/YYYY)
Address	
Phone	Medicare number / IRN / expiry

2 REFERRAL AND CLINICAL DETAILS

Test requested / duration	
Clinical notes / indication / relevant medication	
Referring doctor / provider number	Practice / phone
Referring doctor signature	Request date (DD/MM/YYYY)

3 MEDICARE BULK BILLING - PRE-SERVICE AGREEMENT

Complete this section before the patient signs. Only for services to be bulk billed.

Servicing practitioner name (the practitioner claiming the Medicare benefit)	
Servicing practitioner provider number OR practice address	
Service(s) covered by this agreement / basic service description	Planned service date(s)

I agree to assign my Medicare benefit for the service(s) specified above to the named servicing practitioner. The practitioner agrees to accept that benefit as full payment, with no out-of-pocket charge to me for those bulk-billed services.

Is the person signing the patient? Yes [ ] No [ ]

If no: name and relationship / authority: _____

Patient / authorised assignor signature	Agreement date (DD/MM/YYYY)

Keep the completed agreement with the claim records. Provide a copy to the patient on request.