HOLE IN THE HEART CLINIC

REFERRAL

Date: _____

Patient Name: _____

Patient Phone Number: _____

Date of Birth: _____

Referral for Transcranial Doppler (TCD) to exclude Patent Foramen Ovale (PFO) / right to left shunt for:

(please tick) ✓

- ☐ Stroke assessment
- ☐ Pre-liposuction
- ☐ Pre-lower limb venous or orthopedic surgery
- ☐ Brain fog and exercise intolerance
- ☐ Migraine
- ☐ Scuba diving decompression sickness / nitrogen bubble related stroke

Patient History: _____

_____

_____

_____

_____

_____

Referring Practitioner: _____

Signature: _____

Provider Number and Address:

Location:

- ☐ Gold Coast
- ☐ Brisbane
- ☐ Sydney
- ☐ Melbourne

PH: 1800 000 TCD (1800 000 823)

www.holeintheheartclinic.com.au