



# Care Cardiology

Toowoomba Pty Ltd

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## Patient Details

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_

Phone number: \_\_\_\_\_

## Investigation Required

- |   |  |
|---|--|
| <input type="checkbox"/> Exercise Stress Test   | <input type="checkbox"/> Trans thoracic echocardiogram |
| <input type="checkbox"/> Holter Monitor - <input type="radio"/> 24 hrs <input type="radio"/> 48 hrs | <input type="checkbox"/> Trans oesophageal echo        |
| <input type="checkbox"/> Pacemaker/Defibrillator check  | <input type="checkbox"/> Ambulatory BP Monitor         |

## Clinical Details

## Referring Doctor's Details

Name: \_\_\_\_\_ Provider Number: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Phone number: \_\_\_\_\_

**Note:** Patient is free to choose any other image service provider for this test

