

Patient Referral Form - Dr. Vijaya Venkataraman

Referrer Details

Referrer Name _____

Practice Name _____

Provider Number _____

Phone _____

Email _____

Patient Details

Patient Name _____

DOB _____

Medicare Number _____

Contact Number _____

Email _____

Address _____

Reason for Referral (please check relevant boxes)

- General Medicine - Chronic Disease Management
- Cardiometabolic Medicine - POTS (Postural Orthostatic Tachycardia Syndrome)
- Lipidology - Statin Intolerance
- Lipidology - Lp(a) / Familial Hypercholesterolemia
- Lipidology - PCSK9 / Leqvio Therapy
- Perioperative Assessment - Neuro/Spine Surgery
- Perioperative Assessment - Vascular/Ortho Surgery

Consulting Location

Physician Care Perth – Suite 6/18 Stirling Highway, Nedlands WA

Referral Priority

- Routine Appointment
- Urgent - Please telephone to expedite

Clinical Notes

Referrer Signature -----

Date -----