SMuRFless CAD CLINIC REFERRAL FORM

Dear Dr Stephen Vernon,

I would like to refer the following patient the SMuRFless clinic for further risk factor assessment:

	Patient Contact Details (CONFIDENTIAL)	**Referring Doctor Contact Details**
Name		
Phone Number		
Email Address		
Home Address		
D.O.B.		
Medicare No.	*Ref. #____*	
Provider No.		
Signature		
Date of Referral	_____ / _____ / _____ dd mm yyyy	

ELIGIBILITY CRITERIA:

1a. A diagnosis of atherosclerotic coronary artery disease identified by (tick all that apply):

☐ Invasive coronary angiography ☐ CT coronary angiography

OR

1b. An individual with a positive family history of a first-degree relative with SMuRFless CAD:

☐ Yes, family history

2. No prior history of *any* of the following 4 standard modifiable risk factors:

☐ No prior history of hypertension
☐ No prior history of high cholesterol
☐ No prior history of diabetes mellitus
☐ No history of tobacco smoking in the past 12 months

OTHER QUESTIONS:

1. Has the patient had a previous acute coronary syndrome (ACS) event?
(Not a referral requirement)

☐ No ☐ Yes, Approximate Date: _____ / ____ / _____

Please email this form to: Michael.Gray2@health.nsw.gov.au
Or Fax to: +61 (02) 9926 4937