**REFEFFAL TO PROFESSOR DAVID PLAYFORD**

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| **PATIENT DETAILS** | | | |
| **Patient Name:** | | **DOB:** | |
| **Address:** | | | |
| **Phone:** | | | |
| **Problems** |  | |  |
| Routine review  Angina  New onset chest pain    Shortness of Breath  Heart failure  Arrhythmia | Abnormal testing results  Arrhythmia  Transient ischaemic attack/Syncope | |  |
| **CLINICAL DETAILS**        Allergies | | | |
| **Requesting Doctor**  **Date and Signature:** | | | |

Please phone to arrange an appointment or email/fax us and we will contact you with a convenient time and day.

This practice is a *private billing* practice with payment required on the day of your examination

**Our Office Details**

Mount Medical Centre

Suite 41

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PERTH WA 6000

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