

Refer a Patient for EECF Therapy Assessment

REFERRING CLINICIAN

REFERRING DOCTOR NAME *

DOCTOR EMAIL *

CLINIC / PRACTICE NAME *

DOCTOR / CLINIC PHONE

PATIENT DETAILS

Only patient name and phone are required — Vasoflo will collect any remaining details directly from the patient.

PATIENT NAME *

PATIENT PHONE *

DATE OF BIRTH (DD/MM/YYYY)

PATIENT EMAIL

REASON FOR REFERRAL

Please select all that apply:

- | | |
|---|--|
| <input type="checkbox"/> Refractory angina despite optimal medical therapy | <input type="checkbox"/> Chronic stable angina |
| <input type="checkbox"/> Coronary artery disease with ongoing symptoms | <input type="checkbox"/> Diffuse / complex coronary artery disease |
| <input type="checkbox"/> Not suitable for further revascularisation | <input type="checkbox"/> Persistent symptoms post-PCI |
| <input type="checkbox"/> Persistent symptoms post-CABG | <input type="checkbox"/> Reduced exercise tolerance / functional limitation |
| <input type="checkbox"/> Limited participation in cardiac rehabilitation due to angina or reduced functional capacity | <input type="checkbox"/> Suspected or confirmed microvascular angina / INOCA |
| <input type="checkbox"/> Heart failure with reduced functional capacity | <input type="checkbox"/> Other |
| <input type="checkbox"/> Medication intolerance or limited anti-anginal options | |

BRIEF CLINICAL REASON FOR REFERRAL (OPTIONAL)

ATTACHED DOCUMENTS

When sending this referral, please attach the referral letter and any other relevant documents.

HOW TO SUBMIT THIS REFERRAL

Email: reception@vasoflo.com.au — attach the completed PDF and any supporting documents.

Online: Use the secure referral form at vasoflo.com.au/refer for upload-style submission.

SIGN-OFF

By submitting this referral, the referring clinician confirms the patient has consented to this referral and to Vasoflo contacting them regarding assessment for EECF therapy.

REFERRING CLINICIAN SIGNATURE

DATE (DD/MM/YYYY)