

POTS CLINIC REFERRAL FORM

PATIENT INFORMATION

NAME _____ D.O.B. ___/___/____ M F X

GUARDIAN NAME _____

RELATIONSHIP TO PATIENT _____

EMAIL _____

PHONE _____

CONTACT ADDRESS _____

REFERRING PRACTITIONER

NAME _____ DATE ___/___/____

PROVIDER NUMBER _____

PHONE _____

PRACTICE ADDRESS _____

EMAIL _____

CLINICAL PRESENTATION / POTS SYMPTOMS

- | | | |
|---|---|---|
| <input type="checkbox"/> Postural Intolerance | <input type="checkbox"/> Palpitations / Tachycardia | <input type="checkbox"/> Dizziness / Lightheadedness |
| <input type="checkbox"/> Fainting / Near fainting | <input type="checkbox"/> Chronic Fatigue | <input type="checkbox"/> Brain Fog / Poor Concentration |
| <input type="checkbox"/> Chest Pain / Tightness | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Headache / Migraines |
| <input type="checkbox"/> Nausea / GI Disturbance | <input type="checkbox"/> Exercise Intolerance | <input type="checkbox"/> Tremulousness / Shaking |
| <input type="checkbox"/> Cold/Purple Extremities | <input type="checkbox"/> Sleep Disturbances | <input type="checkbox"/> Temperature dysregulation |

ADDITIONAL CLINICAL NOTES

Unit 5, 2 McCourt Street, West Leederville 6007

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