

Cardiology Department, 15 Portland Place, London W1B 1PT T: 020 7871 2575 E: cardiologyappointments-ukmch@mayo.edu

PATIENT INFORMATION

LAST NAME		FIRST NAME	
DATE OF BIRTH		GENDER	M <input type="checkbox"/> F <input type="checkbox"/> OTHER
INTERPRETER REQUIRED?		PHONE NUMBER	
PATIENT'S ADDRESS		EMAIL	
		FUNDING	SELF PAY <input type="checkbox"/> INSURANCE <input type="checkbox"/> CORPORATE ACCOUNT <input type="checkbox"/> OTHER <input type="checkbox"/>
		INSURANCE COMPANY	
		MEMBERSHIP NUMBER	
		Pre- authorisation number	

EXAMS REQUESTED:

- 12 LEAD ECG
- 24H AMBULATORY BP MONITOR
- 5 LEAD HOLTER MONITOR 24H 48H 72H 7 Days
- ZIO XT - CARDIAC MONITOR 72H 7 Days 14 Days
- TRANSTHORACIC ECHOCARDIOGRAM
- BUBBLE STUDY ECHOCARDIOGRAM
- CARDIOPULMONARY EXERCISE TESTING - CPET - VO2 MAX
- STRESS ECG / EXERCISE TOLERANCE TEST
- EXERCISE STRESS ECHOCARDIOGRAM
- DOBUTAMINE STRESS ECHOCARDIOGRAM
- TRANSOESOPHAGEAL ECHOCARDIOGRAM

CLINICAL INDICATION: Including any relevant medical history, clinical findings and previous investigations results.

CURRENT MEDICATION: Please include patient's current medication list.

ALLERGIES: Please specify patient's known allergies.

NOTE: FOR CARDIAC CT AND MRI REQUESTS, PLEASE COMPLETE THE IMAGING REQUEST FORM
ADDITIONAL INFORMATION

Cardiac arrhythmia	Yes <input type="checkbox"/> No <input type="checkbox"/>
Pacemaker, ICD or ILR	Yes <input type="checkbox"/> No <input type="checkbox"/>
Asthma	Yes <input type="checkbox"/> No <input type="checkbox"/>
Oxygen	Yes <input type="checkbox"/> No <input type="checkbox"/>
Recent Surgery	Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes, please specify	
Infection Risk	Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes, please specify	

MEDICAL REFERRAL MUST BE ATTACHED FOR ALL STRESS PROCEDURES, BUBBLE STUDIES & TRANSOESOPHAGEAL ECHOCARDIOGRAMS

The patient is able to brisk walk on an inclined treadmill?	Yes	No
Reviewed Relative and Absolute Contraindications?	Yes	No
Diabetes	Yes	No
Creatinine level eGfr and date: _____		
Glaucoma?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Pregnant?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Patient Transport	Walking <input type="checkbox"/>	Wheelchair <input type="checkbox"/>
Family Escort	Yes <input type="checkbox"/>	No <input type="checkbox"/>

REFERRING CLINICIAN DETAILS –IR(ME)R 2017 regulations require this form to be signed and dated by the referring clinician. Incomplete forms will be rejected and returned. Please note the referring clinician will assume responsibility for all follow-up care.

Name		Practice Name	
Signature		Address	
GMC Number		Phone	
Date		Email	