

REQUEST FOR CARDIOLOGY INVESTIGATIONS

The Hospital of St. John & St. Elizabeth (Cardiology and Respiratory Department), 60 Grove End Road, London, NW8 9NH
Tel: 020 7806 4080 Fax: 020 7806 4081

DOCTOR:		PATIENT DETAILS:	
Date: Address for Results:		Name: _____ DOB: _____	
		Address: _____	
Tel: _____ Fax: _____		Hospital No: _____ M/F _____	
<input type="checkbox"/> 12 Lead ECG <input type="checkbox"/> Rhythm Strip <input type="checkbox"/> Event Recorder <input type="checkbox"/> Pacemaker Follow Up <input type="checkbox"/> ICD Follow Up <input type="checkbox"/> Cardiopulmonary Exercise Test. CPX <input type="checkbox"/> Exercise Test - <i>(The undersigned confirms that it is safe to proceed with an exercise test)</i> Please tick protocol: <input type="checkbox"/> Bruce <input type="checkbox"/> Modified Bruce		<input type="checkbox"/> 24 Hour Blood Pressure Monitoring <input type="checkbox"/> 24 Hour ECG Monitoring <input type="checkbox"/> 48 Hour ECG Monitoring <input type="checkbox"/> 72 Hour ECG Monitoring <input type="checkbox"/> 7 Day ECG Monitoring (Lifecard) <input type="checkbox"/> Echocardiogram <input type="checkbox"/> Echocardiogram with Bubble Study <input type="checkbox"/> Dobutamine Stress Echocardiogram <input type="checkbox"/> Exercise Stress Echocardiogram	
Beta-Blocker Digoxin BP: _____		All tests are routinely reported unless specified. No report required	
<u>Clinical Information and Reason for Test:</u>		<u>Current Rx.</u>	
<i>Hospital of St. John & St. Elizabeth</i>			
Requested by (signature): _____			
<i>PLEASE BILL PATIENT</i>		<i>PLEASE BILL DOCTOR</i>	
<i>PLEASE BILL PATIENT</i>		<i>INSURED</i>	

This form must be completed by a registered medical practitioner and signed

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