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:

Date:
Address for Results:

Tel: **Fax:**

PATIENT DETAILS:
Name: ***DOB:***

Address:

Hospital No:

M/F

Hospital of St. John & St. Elizabeth

- ☐ 12 Lead ECG ☐ Rhythm Strip
- ☐ Event Recorder
- ☐ Pacemaker Follow Up ☐ ICD Follow Up
- ☐ Cardiopulmonary Exercise Test. CPX
- ☐ Exercise Test - *(The undersigned confirms that it is safe to proceed with an exercise test)*

Please tick protocol: ☐ **Bruce** ☐ **Modified Bruce**

- ☐ 24 Hour Blood Pressure Monitoring
- ☐ 24 Hour ECG Monitoring
- ☐ 48 Hour ECG Monitoring
- ☐ 72 Hour ECG Monitoring
- ☐ 7 Day ECG Monitoring (Lifecard)
- ☐ Echocardiogram
- ☐ Echocardiogram with Bubble Study
- ☐ Dobutamine Stress Echocardiogram
- ☐ Exercise Stress Echocardiogram

Beta-Blocker Digoxin | BP:

All tests are routinely reported unless specified.
No report required

Clinical Information and Reason for Test: Current Rx.

Hospital of St. John & St. Elizabeth

Requested by (signature):

PLEASE BILL PATIENT *PLEASE BILL DOCTOR* *INSURED*

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

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