The Cardiology Unit: Request Form

St John & St Elizabeth Hospital

☐ Outpatient ☐ Daycase ☐ Inpatient

Hospital Number:

Surname:

Forenames:

DOB:.

☐ Male ☐ Female

Address:

Postcode:

Tel / Mobile:

☐ Self Paying ☐ Insured ☐ Third Party

☐ Walking ☐ Wheelchair ☐ Bed / Trolley ☐ Hoist

Investigation(s) requested

Please see guidance notes for referrers overleaf

☐ 12 Lead ECG ☐ Rhythm Strip ☐ Echocardiogram ☐ 24 Hour Blood Pressure Monitoring

☐ Single Channel ECG Monitoring (Ziopatch) ☐ Holter Monitoring ☐ 24h ☐ 48h ☐ 72h ☐ 7day ☐ Event Recorder

☐ Cardiopulmonary Exercise Test ☐ Exercise Treadmill Test *Please tick protocol: ☐ Bruce ☐ Modified Bruce

☐ Pacemaker Follow Up ☐ Medtronic ☐ Boston Scientific ☐ St Jude Medical ☐ ICD Follow Up

☐ Exercise Stress Echocardiogram ☐ Dobutamine Stress Echocardiogram ☐ Echocardiogram with Bubble Study

☐ Pacemaker Stress Echocardiogram ☐ Autonomic Function Assessment Test ☐ Head Up Tilt Test ☐ Carotid Sinus Massage

Clinical Information and Reason for Test:

*Relative Contraindications to ETT

☐ Aortic Stenosis / Murmur ☐ LBBB/AF on ECG

☐ Resting Chest Pain ☐ History of Ventricular Arrhythmias

☐ HOCM ☐ Angina <1/12 post MI / PCI / CABG

☐ Problems with mobility (Will patient be able to walk unaided on a treadmill? E.g. arthritis of hip / knee)

Risk Factors

☐ FHx Premature IHD ☐ Murmur ☐ Smoker ☐ Diabetes

BP (mmHg)

BMI (kg/m^2)

Alcohol (unit/week)

Cholesterol

Past Cardiac History

☐ Confirmed Angina ☐ Heart Failure ☐ CVA ☐ Prior MI ☐ Pacemaker

☐ Asthma / COPD ☐ Hypertension ☐ Atrial Fibrillation ☐ Hyperlipidaemia

☐ Cardiac Surgery ☐ Other Arrhythmia ☐ NYHA Grade I ☐ II ☐ III ☐ IV ☐

Presenting Symptoms

☐ Chest Pain ☐ Palpitations ☐ Syncope (or pre-syncope) ☐ Shortness of Breath ☐ Oedema ☐ PND / Orthopnoea

Current Medication:

☐ Beta-Blocker ☐ Digoxin

**Signature of Referring Clinician:

(please read the Referrer's disclaimer overleaf)

Date of Request:

Email for Results:

Name of Referring Clinician:

Tel:

Mobile:

SS. John and Elizabeth Charity, Registered Charity No: 235822 Version 1 SP3101-01/2022 Review Date: January 2025

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Guidance Notes for Referrers

- Cardiac Investigations will only be performed upon written request signed by a registered medical or dental practitioner or by an authorised non-medical practitioner.
- Referrals (request form or letter) must precede or accompany the patient. Faxes are accepted.
- All requests must carry sufficient information to identify the patient, normally consisting of the first name, middle initial (if any), family name, date of birth and address.
- All requests must carry sufficient clinical information to enable the requested examination to be justified in line with national and local guidelines.
- All requests shall clearly state the examination requested.
- All requests must include the contact details of the referring clinician including address, telephone and fax numbers.

**Referrer's Declaration

By signing the request form you are confirming the following:

- **The correct details have been provided**
- **You have discussed the examination including any intervention**
- **You have taken into account the possibility of pregnancy**
- **There are no known contra-indications to performing the requested examination**
- **You will ensure the examination results are recorded in the patient's records**

For Cardiology Unit Use Only:

Affix Patient Label

Request Form Check

- ☐ Three Points of ID Checked
- ☐ Previous testing Checked
- ☐ Examination Checked with Patient
- ☐ Protocol Confirmed
- ☐ Pregnancy Status Documented

Consent for ECG, HR / BP Monitoring, AFT, PMC and ICD FU

The patient has been provided with the consent information sheet(s) for the procedure(s) Yes ☐ No ☐

The patient has given verbal informed consent to the procedure(s) Yes ☐ No ☐

Name of operator: Signed: Date:

Consent for ETT, CPET, HUT and Exercise Stress Echocardiogram

The patient has been provided with the consent information sheet(s) for the procedure(s) Yes ☐ No ☐

Statement of the patient/person with parental responsibility for patient:
I have read all of the information provided and all of my questions / concerns have been answered.
I agree to the procedure(s).

Signed (patient): Date:

Name (print):

Consent for Dobutamine Stress Echocardiogram, Bubble Study and Carotid Sinus Massage

You must use Hospital Consent Form 3 or 4. Please refer to the Hospital Consent Policy for further guidance.