

direct line. 020 7616 7664

direct fax. 020 7616 7688

request for  
cardiology

the London clinic 

Patient details

Surname: \_\_\_\_\_ Forename: \_\_\_\_\_ Room N°/Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Fee to be charged to Patient/Company/Doctor

Test required  
(please tick box)

ECG

24hr Ambulatory Blood Pressure Monitor

Event Monitor

24hr Ambulatory ECG

Echo Cardiogram

48hr Ambulatory ECG

Please Tick if Report is Required

Exercise Tolerance Test (see below)

Clinical details/provisional diagnosis

(Please state, if relevant, any symptoms/recent medical history which may require an exercise tolerance test to be medically supervised)

Is the patient receiving medication?

Yes/No

Details: \_\_\_\_\_

Referring clinician

Name: \_\_\_\_\_

Address for report: \_\_\_\_\_

I confirm that I have examined the above named patient in the past 72 hours.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_