THE LONDON CLINIC

Cardiology request

PATIENT INFORMATION

*indicates mandatory fields

*TLC unit no. (if known) L

*Title

*DOB dd/mm/yyyy)

*Surname

*Forename(s)

*Gender M F

IP OP DC

Room

*Referrer's full name and / or practice stamp

Payment method ☐ Insurance ☐ Embassy ☐ Self-Pay ☐ Sponsor

Payment provider

Member no.

Authorisation no.

Patient's tel no.

Patient's email

Patient's address

Copy of reports to

TEST REQUIRED (please tick box)

- ☐ Resting ECG
- ☐ Exercise Tolerance Test (see below)
- ☐ Echocardiogram
- ☐ Stress Echocardiogram Exercise / Dobutamine (please circle)
- ☐ 24hr Ambulatory Blood Pressure Monitor
- ☐ Ambulatory Heart Rhythm Monitor
  - ☐ Up to 3 days
  - ☐ Up to 7 days
  - ☐ Up to 14 days

RECORDING TIMES

24h 48h 72h 7 days 14 days 28 days

CLINICAL INFORMATION/PROVISIONAL DIAGNOSIS

Is the patient receiving medication? ☐ Yes ☐ No

If yes, please give details

REFERRING CLINICIAN

Name:

For exercise tolerance testing the referring clinician is required to make the following declaration and by signing this request form accepts the conditions for exercise stress testing are fulfilled:

- I confirm that I have examined the above named patient within the past 72 hours and consider the patient suitable to undertake an exercise tolerance test supervised by a cardiac physiologist.
- I have explained to the patient the purpose of this test and the potential risks associated with the examination.

Referrer's signature Date / /

A **MAIN HOSPITAL**
20 Devonshire Place
London W1G 6BW

B **THE DUCHESS OF DEVONSHIRE WING**
22 Devonshire Place
London W1G 6JA

C **CARDIOLOGY DEPARTMENT**
5 Devonshire Place
London W1G 6HL

D **CONSULTING ROOMS**
145 Harley Street
London W1G 6BJ

E **PATHOLOGY SERVICES AND CONSULTING ROOMS**
120 Harley Street
London W1G 7JW

F **CONSULTING ROOMS**
116 Harley Street
London W1G 7JL

G **EYE CENTRE AND CONSULTING ROOMS**
119 Harley Street
London W1G 6AU