Referral Form – Cardiology

PLEASE COMPLETE THIS FORM IN **BLOCK CAPITALS IN BLACK INK**

Cambridge
HEART CLINIC

Patient Number (For Clinic use only):

1 REFERRAL DETAILS

Date of request:	Date required:	Patient Type:
Time required:	AM ☐ PM ☐	Self Pay ☐ Insured ☐

2 PATIENT DETAILS

Title:	First Names:	Surname:
Age:	DOB:	Sex:
Address:		
Postcode:	Email Address:	
Home Tel:	Work Tel:	Mobile Tel:

3 REFERRING DOCTORS DETAILS

GP Name:	GP Tel:
GP Address:	
	GP Postcode:
GP Fax:	GP Email:

4 TYPE OF REFERRAL

New Cardiology Consultation ☐	**Specific Tests Required** ☐	Resting 12 lead ECG ☐
Follow-up Consultation ☐		Exercise ECG ☐
		Echocardiogram ☐
		24 hour ECG ☐
		24 hour BP ☐
		Cardiovascular screening ☐
	Other (please state) ☐	

5 REASON FOR TEST AND RELEVANT CLINICAL DETAILS

6 DRUG HISTORY

7 ALLERGIES

8 REFERRING DOCTORS SIGNATURE

REFERRAL FAX HOTLINE: 01223 349348