

Referral Form – Cardiology

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

Patient Number (For Clinic use only):		
1 REFERRAL DETAILS		
Date of request:	Date required:	Patient Type:
Time required:	AM <input type="checkbox"/> PM <input type="checkbox"/>	Self Pay <input type="checkbox"/> Insured <input type="checkbox"/>
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 <input type="checkbox"/>	Specific Tests Required <input type="checkbox"/>	Resting 12 lead ECG <input type="checkbox"/>
Follow-up Consultation <input type="checkbox"/>		Exercise ECG <input type="checkbox"/>
		Echocardiogram <input type="checkbox"/>
		24 hour ECG <input type="checkbox"/>
		24 hour BP <input type="checkbox"/>
		Cardiovascular screening <input type="checkbox"/>
	Other (please state) <input type="checkbox"/>	
5 REASON FOR TEST AND RELEVANT CLINICAL DETAILS		
6 DRUG HISTORY		7 ALLERGIES
8 REFERRING DOCTORS SIGNATURE		

REFERRAL FAX HOTLINE: 01223 349348