

CARDIOLOGY STRESS TEST REQUEST FORM



Cardiology department, direct line: (020) 7460 5756/5755
 Cardiology department, direct fax: (020) 7835 2431

PLEASE BRING THIS FORM WITH YOU WHEN YOU ATTEND THE HOSPITAL

All sections of this form must be fully completed

Referring doctor: Name:..... Address:..... Phone:..... Fax:.....	Patient details: Place sticker here Name:..... Date of birth:..... MRN:.....
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ESSENTIAL PATIENT INFORMATION

Reasons for investigation Medical check-up:..... Chest pain:..... Angina:..... Hypertension:..... Shortness of breath:..... DVLVT:..... Pilot screen:.....	Symotoms: Previous ECGs at Cromwell Hospital Yes..... No..... Date.....
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PATIENT HISTORY	Yes	No	ADDITIONAL INFORMATION	Y	N
Myocardial Infarct Date.....			Current drug regime: Digoxin Beta blockers Aspirin		
CAD					
Valve disease					
Heart failure					
Heart surgery					
Hypertension			Beta Blockers should preferably be stopped 24 hours prior to the test		
Pulmonary Disease			Previous ECG findings:		
Pulmonary Vascular Disease					
Diabetes					
Locomotion problem: <i>Intermittent claudication, Knee or Hip Problems</i>					

CONTRAINDICATIONS FOR STRESS TESTING

- UNSTABLE ANGINA
- AORTIC STENOSIS
- ACUTE M.I.
- UNCONTROLLED HYPERTENSION

HAVE YOU DISCUSSED THIS TEST WITH THE PATIENT	Exercise stress test charge	540103
	Referring clinical signature	
	Signature:..... Date:.....	