

## CARDIOLOGY DIAGNOSTIC TEST REQUEST FORM

Fax referral form for appointment to: 020 7881 4172

Telephone appointments: 020 7881 4171

Patient name: \_\_\_\_\_ Date: \_\_\_\_\_  
 Hospital No: \_\_\_\_\_ Appointment time: \_\_\_\_\_  
 Date of birth: \_\_\_\_\_

### TESTS REQUIRED:

TEST	
E.C.G	Exercise stress test
24 hour blood pressure	Basic spirometry
24 hour Holter Monitor	Full lung function
48 hour Holter Monitor	Echocardiogram
7 day Holter Monitor	Stress echocardiogram
Loop recorder	Echo with Bubble Contrast injection
Pacemaker check	
Defibrillator check	
Reveal interrogation	
CO & Resync Assessment	

### Please indicate if report is required

Clinical details:	YES	NO
Recent MI		
Chest Pain		
S.O.B.		
Murmur		
Palpitations		
Recent ECG		
ECG abnormal?		

Indications/comments:  
 \_\_\_\_\_

Requested by:  
 \_\_\_\_\_

Address (for results):  
 \_\_\_\_\_

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