Cardiology Stress Test Request Form

Cromwell Hospital

Telephone: 020 7460 5700 Extension: 5410/ 7305 * **Email:** cardiacoutpatients@cromwellhospital.com * **Clinic hours:** 9.30am to 7.30pm

PLEASE BRING THIS FORM WITH YOU WHEN YOU ATTEND THE HOSPITAL
(FAILURE TO DO SO CAN CAUSE DELAYS OR CANCELLATION)
All sections of this form must be fully completed

Referring doctor:	Patient details: Place sticker here
Name:.....	Name:.....
Email:	Date of birth:.....
	MRN:.....

ESSENTIAL PATIENT INFORMATION

Reason/s for investigation (*Please tick one or more)*
Medical check-up : _____
Chest pain/Angina:_____
Hypertension : _____
Shortness of breath:_____
DVLT : _____
Pilot screen : _____

Symptoms:

Exercise stress test charge 540103

PATIENT HISTORY	Yes	No
Myocardial Infarct Date.....		
CAD		
Valve disease		
Heart failure		
Heart surgery		
Hypertension		
Pulmonary Disease		
Pulmonary Vascular Disease		
Diabetes		
Locomotion problem: *Intermittent claudication, Knee or Hip Problems*		

Current drug regime:

	Y	N
Digoxin		
Beta blockers		
Aspirin		

Beta Blockers should preferably be stopped 24 hours prior to the test.

Previous ECG findings:

Have you discussed this test with the patient or parent/guardian:

YES NO

Additional information:

CONTRAINDICTIONS FOR STRESS TESTING

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

Referring clinician signature (mandatory)

Signature:.....

Date:.....