Cardiac Investigations Request Form

Issue **January 2021** Review **January 2024**

NEW VICTORIA HOSPITAL

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Referring Clinician: _____

_____

Address: _____

_____

_____

_____

Fax no. (for results): _____

Tel no.: _____

Surname: _____

First name: _____

Date of birth: _____

Address: _____

_____

Post code: _____ **Tel no.:** _____

Hospital no.: _____

Insurance company: _____

Policy no.: _____

Clinical Information (IRmER requires a full history):

Medication

Patient Transport:

Inpatient ☐ **Room no.** _____

Walking ☐

Chair ☐

Bed ☐

Presenting Symptoms:

Recent MI ☐

Chest pain ☐

Shortness of breath ☐

Cardiac Murmur ☐

Palpitations ☐

Abnormal ECG ☐

Examination(s) Required:

Resting 12 lead ECG ☐

24 hour ECG monitor ☐

48 hour ECG monitor ☐

7-14 day ECG monitor ☐

24 hour blood pressure monitor ☐

Transthoracic Echocardiogram ☐

Exercise Treadmill Test ☐
(Appendix A overleaf **must** be completed)

Stress Echocardiogram:

1. Treadmill ☐

2. Dobutamine ☐

Patient on beta-blocker? **Yes** ☐ **No** ☐

Beta-blocker stopped for 48hrs prior? **Yes** ☐ **No** ☐

Comments

For Cardiac Investigations Department Use Only.

Appointment Information

Date

Time

Requesting Physician:

Signature | **Date**

Appendix A: Request Form for Low Risk Clinical Exercise Tolerance Test

This form must be completed to accept the referral. Incomplete forms will be returned the referrer.

This test is suitable for non-symptomatic patients who require investigation to obtain DVLA licences; pilot licences. All other patients should be considered for a Stress Echocardiogram as per NICE guidelines.

Name: _____ **Address:** _____

Hospital no.: _____

Date of birth: _____

Referral date: _____

Referring clinician: _____

Contra-Indications (If any exist then consider a medically supervised ETT. (Please tick to indicate not present):	
Unstable angina	NOT PRESENT ☐
Angina <1month following MI, PTCA, CABG	NOT PRESENT ☐
Known Left main stem stenosis	NOT PRESENT ☐
Aortic stenosis/HOCM(hypertrophic obstructive cardiomyopathy)	NOT PRESENT ☐
BP <90mmHg or resting SBP >180mmHg or DBP >100mmHg	NOT PRESENT ☐
History of ventricular arrhythmias/tests for arrhythmia provocation	NOT PRESENT ☐
ECG demonstrates LBBB, AF or WPW	NOT PRESENT ☐

Relevant Medical Details		
What question do you want the test to answer?		
Do you require a symptom limited or maximal test?	SYMPTOM LIMITED ☐	OR MAXIMAL ☐
Bruce protocol is standard. If required, please indicate another?	YES ☐	OR NO ☐

Current Medication (Certain medications may reduce the sensitivity of the exercise test to IHD)
Do you wish the patient to exercise on full medication?

Medical Consent		
I have seen and examined this patient and the resting ECG; and it is safe to proceed with a medically unsupervised test; and that none of the contra-indications to ETT exist.		
Signature	**Name**	**Date**

Offical Use Only

Request form checked by:	**Date**
If appropriate, reason for referral back to requesting physician:	