

# CARDIOLOGY DEPT REQUEST FORM



BON SECOURS HOSPITAL

Glasnevin, Dublin 9

Modern Healthcare, Traditional Values

(All fields must be completed)

Please fax completed form to **01 8065398**

## REFERRER DETAILS

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Tel: \_\_\_\_\_ Fax: \_\_\_\_\_

Signature: \_\_\_\_\_

## PATIENT DETAILS

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Tel: \_\_\_\_\_

DOB: \_\_\_\_\_

Private Health Insurance Yes ☐ No ☐

## PATIENT HISTORY

Cardiac History (eg. CABG, PCI, CAD etc)

Symptoms (eg. SOB, Chest pain etc)

## TEST(S) REQUIRED (please tick)

|                                  |                       |                |                       |                             |                       |
|----------------------------------|-----------------------|----------------|-----------------------|-----------------------------|-----------------------|
| ECG                              | <input type="radio"/> | Event Monitor  | <input type="radio"/> | Stress Echo                 | <input type="radio"/> |
| Exercise Stress Test (see below) | <input type="radio"/> | Pacing Check   | <input type="radio"/> | Transoesophageal Echo (TOE) | <input type="radio"/> |
| Holter Monitor                   | <input type="radio"/> | Echocardiogram | <input type="radio"/> | Tilt Table Test             | <input type="radio"/> |
| Ambulatory BP Monitor            | <input type="radio"/> |                |                       |                             |                       |
| Other Test (please specify)      | _____                 |                |                       |                             |                       |

## CURRENT MEDICATIONS (please list all)

## EXERCISE STRESS ECG Test only

|                       | YES                   | NO                    | Contraindications ( <u>ALL</u> fields <u>MUST</u> be completed) | YES                   | NO                    |                        | YES                   | NO                    |
|-----------------------|-----------------------|-----------------------|---|-----------------------|-----------------------|------------------------|-----------------------|-----------------------|
| Chest Pain            | <input type="radio"/> | <input type="radio"/> |   |                       |                       | BP >180/100            |                       |                       |
| Family History of CAD | <input type="radio"/> | <input type="radio"/> | Recent MI (< 1 Month)   | <input type="radio"/> | <input type="radio"/> | Symptomatic arrhythmia | <input type="radio"/> | <input type="radio"/> |
| Smoker                | <input type="radio"/> | <input type="radio"/> | Unstable angina   | <input type="radio"/> | <input type="radio"/> | Inability to Exercise  | <input type="radio"/> | <input type="radio"/> |
| Diabetes              | <input type="radio"/> | <input type="radio"/> | Troponin T > 0.01   | <input type="radio"/> | <input type="radio"/> |                        |                       |                       |
| Previous MI           | <input type="radio"/> | <input type="radio"/> | Aortic stenosis   | <input type="radio"/> | <input type="radio"/> |                        |                       |                       |

Why is this investigation required?

I confirm no contraindications exist: \_\_\_\_\_ GP Signature Date: \_\_\_\_\_