BON SECOURS HOSPITAL
Dublin 9

CARDIOLOGY DEPARTMENT

EXERCISE STRESS TEST BOOKING FORM

Patient name: _____

Address: _____

_____

Date of birth _____ Age _____

This form must be completed and must accompany the patient in order for the Exercise Stress Test to be performed

Current medications _____

_____

Past history / Relevant Medical Information _____

_____

NB PLEASE NOTE THE FOLLOWING CONTRA-INDICATIONS FOR EXERCISE STRESS TEST

- Acute myocardial infarction Yes ☐ No ☐
- Unstable or crescendo angina Yes ☐ No ☐
- Severe aortic stenosis Yes ☐ No ☐
- Untreated congestive cardiac failure or pulmonary oedema Yes ☐ No ☐
- Acute myocarditis or pericarditis Yes ☐ No ☐
- Recent thromboembolism Yes ☐ No ☐
- Acute infectious illness Yes ☐ No ☐

GP Signature _____ Date _____

If you have any queries regarding the above please contact the Outpatient/Central Registration Department – telephone number 01 8082300 or fax 8082309