CARDIOLOGY DEPT REQUEST FORM

BON SECOURS HOSPITAL DUBLIN
Advanced Medicine Exceptional Care

(All fields must be completed)
Please email completed form to dublincardiologybookings@bonsecours.ie
or fax to 01 806 5398

REFERRER DETAILS

Name: _____

Address: _____

_____

Tel: _____ Fax: _____

Signature: _____

PATIENT DETAILS

Name: _____

Address: _____

_____

Tel: _____

DOB: _____

Private Health Insurance Yes O No O

PATIENT HISTORY

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

Symptoms (eg. SOB, Chest pain etc)

TEST(S) REQUIRED (please tick)

ECG	O	Event Monitor	O	Stress Echo	O
Exercise Stress Test (see below)	O	Pacing Check	O	Transoesophageal Echo (TOE)	O
Ambulatory BP Monitor	O	Echocardiogram	O	Tilt Table Test	O

Holter Monitor (please indicate no. of days) O 1 day O 2 day O 3 day O 5 day

Other Test (please specify) _____

CURRENT MEDICATIONS (please list all)

EXERCISE STRESS ECG Test only

	YES	NO
Chest Pain	O	O
Family History of CAD	O	O
Smoker	O	O
Diabetes	O	O
Previous MI	O	O

Contraindications (ALL fields MUST be completed)

	YES	NO
Recent MI (< 1 Month)	O	O
Unstable angina	O	O
Troponin T > 0.01	O	O
Aortic stenosis	O	O

	YES	NO
BP >180/100	O	O
Symptomatic arrhythmia	O	O
Inability to Exercise	O	O

Why is this investigation required?

I confirm no contraindications exist: _____ GP Signature Date _____

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