The Wellington Hospital

Tel: 020 7483 5895 **CARDIOLOGY DEPARTMENT** Fax: 020 7483 5249

## PATIENT INFORMATION

| Patient's last name: | First: | ❑ Mr. ❑ Mrs.<br>❑ Miss ❑ Ms.<br>Other: | Date of Birth / / |
|---|---|---|---|
| Contact Phone Number: | | ❑ M ❑ F | Nationality: |
| Address: | | | |
| | | | |
| Postcode: | Email: | | |

## INSURANCE INFORMATION

Is this patient covered by insurance? ❑ Yes Insurance Policy Number: ❑ No – patient is self-pay

Authorisation Number:

## REFERRING PHYSICIANS DETAILS

| Referring Doctor: (please print clearly) | | |
|---|---|---|
| Address (for results) | | |
| | Postcode: | Tel: |
| Reason for referring patient: | | |
| | | |

## PATIENT HISTORY (PLEASE TICK *ALL* RELEVENT CONDITIONS)

| | | | | | |
|---|---|---|---|---|---|
| Severe/rest/unstable angina | ❑ Yes ❑ No | Angina<1 month post MI//PTCA /Stent / CABG | ❑ Yes ❑ No | Left main stem stenosis | ❑ Yes ❑ No |
| Aortic Stenosis | ❑ Yes ❑ No | HOCM | ❑ Yes ❑ No | Hypotension (SBP<90mmHg) | ❑ Yes ❑ No |
| Hypertension SBP>180Hg DBP>100mmHg | ❑ Yes ❑ No | Ventricular arrhythmias | ❑ Yes ❑ No | LBBB or pacing on ECG | ❑ Yes ❑ No |
| Other uncontrolled/symptomatic arrhythmia | ❑ Yes ❑ No | Signs of Heart Failure | ❑ Yes ❑ No | Other valve disease or murmur | ❑ Yes ❑ No |
| Previous CABG/PTCA/Angiogram | ❑ Yes ❑ No | Smoker (last 10 years) | ❑ Yes ❑ No | Family History | ❑ Yes ❑ No |
| Hypercholesterolemia | ❑ Yes ❑ No | Diabetes | ❑ Yes ❑ No | Peripheral vascular disease | ❑ Yes ❑ No |
| Cerebral vascular disease | ❑ Yes ❑ No | | | | |

## PATIENTS CARDIAC MEDICATION/OTHER INFORMATION

## INVESTIGATIONS REQUIRED (PLEASE TICK AS APPROPRIATE)

| | | | |
|---|---|---|---|
| Resting ECG | ❑ Yes | 24/48/72 hour ECG monitoring (Please specify) | ❑ Yes |
| Echocardiogram | ❑ Yes | 7 day ECG monitoring | ❑ Yes |
| Echocardiogram bubble study | ❑ Yes | Loop ECG Monitoring (2/4 weeks) | ❑ Yes |
| Bruce protocol Exercise Stress Test | ❑ Yes | 24 hour BP monitoring | ❑ Yes |
| Modified Bruce Exercise Stress Test | ❑ Yes | Pacemaker/ICD check (Please specify) | ❑ Yes |
| Other (Please specify) | | | |

| **SIGNATURE OF REFERRING PHYSICIAN:** | | **DATE** | / / |
|---|---|---|---|

***OFFICE USE : APPOINTMENT BOOKED FOR.................................................................. PLEASE INITIAL............................***