

# Investigation Request Form

## Cardiac Clinic

10-11 Bustrade Place, London W1U 2HX  
136 Harley Street, London W1G 7JZ



Harley Street Centres

**Bookings hotline** tel: **0845 456 8878** fax: **020 7935 7715** email: **london@alliance.co.uk**

### Patient details

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

Date of Birth: \_\_\_\_\_

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

Postcode: \_\_\_\_\_

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

Email: \_\_\_\_\_

Male  Female

Start date of last Menstrual Period (if applicable) \_\_\_\_\_

Patient arrival: Trolley  Wheelchair  Walking

Funding: NHS  Self Funded  Private Patient

Patient's insurance company: \_\_\_\_\_

Membership number: \_\_\_\_\_

Pre-authorisation number (if known): \_\_\_\_\_

**Please note:** Uninsured patients and patients without pre-authorisation are required to pay on the day of their appointment.

### Referral information

Chest X-ray: PA  Lateral

Resting 12-lead ECG

Ambulatory ECG Monitoring:

24hrs  48hrs

Ambulatory 24hr BP Monitoring

Event recorder weeks

Transthoracic Echocardiogram

Carotid Doppler

### Presenting Symptoms:

Recent MI? Yes  No

Chest Pain? Yes  No

Shortness of Breath? Yes  No

Cardiac Murmur? Yes  No

Palpitations? Yes  No

Recent ECG? Yes  No

Abnormal ECG? Yes  No

### Reason for referral:

### Relevant previous medical history

Details (including any surgery and current medication):

Please include copies of any recent X-rays or scan reports

### Referring Clinician's details

IR(ME)R 2000 regulations require this form  
to be signed by the referring Clinician

Consultant/GP name: \_\_\_\_\_

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

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

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

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

Email: \_\_\_\_\_