Investigation Request Form

Cardiac Clinic

10-11 Bustrode 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: ____________________

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____________________ 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: ____________________

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Tel: ____________________

Fax: ____________________

Email: ____________________

For general enquiries tel: **+44 (0) 20 7935 7711** email: **london@alliance.co.uk** web: **www.alliancemedicallondon.co.uk**