BLACKROCK HEALTH

BLACKROCK CLINIC

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Cardiology Booking Form

PATIENT DETAILS

(Please Print)

Name: _____ Date of Birth: _____/_____/_____

Address: _____

Phone: _____ Email: _____ BRC MRN: _____

ED: ☐ GP: ☐ CON: ☐ IN-PATIENT: ☐ Ward: _____ Room: _____

Appears at risk of falling: ☐ Patient Infection Status: _____

Health Insurance: Yes ☐ No ☐ Insurer _____ Policy No: _____

Public Patient: Yes ☐ No ☐ Hospital PO /UAN number: _____

Imaging Required: Echo ☐ DSE ☐ TOE ☐ Stress Echo ☐ Bubble Study ☐

Test Required: Holter ☐ BP ☐ Event ☐ ECG ☐ Pacing ☐ Stress ECG ☐

Clinical Indication: _____

_____

_____

Scan required: Urgent ☐ Next available ☐ Future date (please specify):_____

Referrer's Name: _____ Reg No: _____

(Please Print)

Referrer's Signature: _____ Date: _____

Referrer's Address: _____

NB: MUST BE COMPLETED IN CASE OF E.S.T

TECHNICIAN SUPERVISED E.S.T.

"I HAVE EXAMINED THIS PATIENT AND REVIEWED THE ECG. THE PATIENT DOES NOT HAVE AORTIC STENOSIS, CARDIOMYOPATHY, A SERIOUS CARDIAC ARRHYTHMIA OR AN ACUTE MYOCARDIAL INFARCT. IT IS SAFE TO PERFORM A MEDICALLY UNSUPERVISED TREADMILL TEST."

Signed: _____ Date: _____

PLEASE ENSURE THE REQUEST FORM IS FULLY COMPLETED, SIGNED AND DATED
INCOMPLETE REQUESTS WILL NOT BE ACCEPTED AND WILL CAUSE PATIENT DELAYS