

Cardiac & Pulmonary Test Referral Form

GP referrals: fax to 020 7349 3892 **INTERNAL referrals:** fax to 020 7881 4172

PATIENT DETAILS					
TITLE	SURNAME		GENDER (Please tick) MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>		
FORENAME			HOSPITAL NO	DATE OF BIRTH	
ADDRESS					
					POSTCODE
EMAIL ADDRESS				TEL NO	
APPOINTMENT DETAILS		DATE		TIME	
REFERRER'S DETAILS					
NAME			SIGNATURE		
ADDRESS					
TEL NO		FAX NO		DATE	
CARDIAC TESTS REQUIRED (Please tick)					
E.C.G <input type="checkbox"/>			EXERCISE STRESS TEST		
24 HOUR BLOOD PRESSURE <input type="checkbox"/>			SPHYGMOCOR PULSE PRESSURE <input type="checkbox"/>		
24 HOUR HOLTER MONITOR <input type="checkbox"/>			MONITORING <input type="checkbox"/>		
48 HOUR HOLTER MONITOR <input type="checkbox"/>			ECHOCARDIOGRAM <input type="checkbox"/>		
7 DAY HOLTER MONITOR <input type="checkbox"/>			ENDOPAT <input type="checkbox"/>		
STRESS ECHO <input type="checkbox"/>			ECHO WITH BUBBLE CONTRAST <input type="checkbox"/>		
			INJECTION <input type="checkbox"/>		
PULMONARY TESTS REQUIRED (Please tick)					
FULL LUNG FUNCTION <input type="checkbox"/>			MANNITOL CHALLENGE <input type="checkbox"/>		
SPIROMETRY <input type="checkbox"/>			REVERSIBILITY <input type="checkbox"/>		
PLEASE INDICATE IF REPORT IS REQUIRED (Please tick)					
CLINICAL DETAILS	YES	NO	CLINICAL DETAILS	YES	NO
RECENT MI	<input type="checkbox"/>	<input type="checkbox"/>	PALPITATIONS	<input type="checkbox"/>	<input type="checkbox"/>
CHEST PAIN	<input type="checkbox"/>	<input type="checkbox"/>	RECENT ECG	<input type="checkbox"/>	<input type="checkbox"/>
S.O.B	<input type="checkbox"/>	<input type="checkbox"/>	ECG ABNORMAL	<input type="checkbox"/>	<input type="checkbox"/>
MURMUR	<input type="checkbox"/>	<input type="checkbox"/>			
INDICATIONS/COMMENTS					



Our GP Liaison department offers GPs, patients and healthcare professionals a fast and efficient referral service to The Lister Hospital's consultants.

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