Queen Anne
Street Medical Centre

Cardiac Investigation Request Form

Patient name: **DOB:** **Address:** **Home Telephone:** **Mobile:**	**Referring Consultant / GP:** **Signature:** **Contact Address:** **Contact Telephone:** **Fax:**

Next of Kin: **Relationship:** **Contact Details:**	**GP Name and Contact Details:**

Please tick as applicable:

12 Lead Electrocardiogram ☐

ECG Exercise Test (bike) ☐

Suspected Diagnostic/Clinical Information: Auscultatory Findings:
Blood Pressure: HR: Height: Weight:

Previous ECG	Previous Echo
Yes ☐ No ☐	Yes ☐ No ☐
Please enclose copy/ies as applicable.	
Current Medication:	
Digoxin: Yes/No	

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