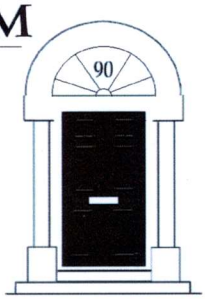
CARDIAC INVESTIGATION REQUEST FORM

SLOANE STREET INVESTIGATIONS
90 SLOANE STREET
LONDON SW1X 9PQ
TEL: 0207 201 5050
PLEASE FAX COMPLETED FORM TO: 0207 201 5070
PLEASE EMAIL COMPLETED FORM TO: enquiries@sloanestreetinvestigations.com

ALL SECTIONS MUST BE COMPLETED BY THE REFERRER



SLOANE STREET INVESTIGATIONS

Patient Information:

Please complete form in capitals using black ink and ticking/deleting as appropriate

First name: _____

Surname: _____

Address: _____

_____

_____

Postcode: _____ Telephone: _____

Mobile: _____

Date of Birth: ___ ___ ___ Male ☐ Female ☐

Insurance Co:

Authorisation No:

Policy No:

Self-funding: ☐

Appointment:

Date:

Time:

Investigation required:

Echocardiogram - Transthoracic : ☐

Stress Echocardiogram: ☐

24 hour Ambulatory **Blood Pressure Monitor**: ☐

Cardiac Event Monitor (Alive Core): ☐

Up to **two week** recording monitor (Zio Device): ☐

Holter Monitors

24 hours: ☐

48 hours: ☐

5 day: ☐

Clinical Details/ Provisional Diagnosis:

Medications:
If yes; please give details

Allergies:
If yes; please give details

Please add resting ECG:
(If this test was performed).
This will help interpretation
If you would like us to do ECG please state

THIS FORM IS A LEGAL DOCUMENT.
REFERRER'S DECLARATION:

The correct patient details have been provided.
I have discussed the examination with the patient/guardian.

Referrer's signature:

Date:

Referrer's name and address or stamp:

Would you prefer results to be
emailed: faxed: Please give contact details: