UME GROUP DIAGNOSTICS

Cardiology Request Form

BOOKINGS: 0800 222 9048 **EMAIL: client.support@umegroup.com**

Harley Street Fax 0844 567 8218

Patient details (affix label if available)

Title Other	Address:
First name:	
Surname:	
DOB: Male ◯ Female ◯	Postcode:
Telephone No:	Self pay ◯ Insured ◯ NHS ◯ Third party ◯
Mobility: Mobile ◯ Non-mobile ◯	Insurance Co:
Patient ID:	Policy number:

Cardiac Investigations

◯ ECG
◯ Exercise Stress ECG*
◯ Echocardiogram
◯ Exercise Stress Echocardiogram
◯ Dobutamine Stress Echocardiogram
◯ Echocardiogram Bubble Study
◯ 24 hr ECG Holter Monitor
◯ 48 hr ECG Holter Monitor
◯ 72 hr ECG Holter Monitor
◯ 7 day ECG Holter Monitor
◯ 24 hr BP Monitor
◯ Cardiac Memo
◯ Bloods
◯ Urine
◯ Pacemaker Check

Cardiac Imaging

◯ CT Angiogram
◯ CT Coronary Angiogram
◯ CT Calcium Score
◯ Cardiac MRI
◯ Cardiac Open MRI
◯ Carotid - Ultrasound

Date of follow up appointment: Routine ◯ Urgent ◯

Clinical history and reason for referral

CT Coronary Angiogram—In line with Royal College of Radiologist Guidelines a recent (last three months EGFR must be available prior to imaging, and for patients with BP>60bpm beta blockers must be prescribed prior to arrival.

Referring clinician's details (stamp or affix label if available)

Imaging: If you wish to discuss this referral with the reporting clinician prior to booking, please tick here ☐

Exercise Stress ECG*: by signing this form you are confirming that you have assessed the above patient for this test and that he/she is fit to undergo this and has no Aortic Stenosis/Murmur or other contraindications.

Referrer name:

Signature of Referring clinician :

GMC number:

Contact Tel No:

Please indicate how you would like to receive the results of the investigation?

◯ **By Post** - Postal Address:

◯ **By Fax** - Fax Number:

◯ **By Email** - Email Address:

Cardiac Imaging: A CD of images will be given to the patient. Do you wish to receive a copy? ◯ Yes ◯ No

Further copies of this form are available to download at www.umediagnostics.com

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