

## PHYSIOLOGICAL MEASUREMENT REQUEST FORM (INCLUDING ECHOCARDIOGRAPHY)

**PLEASE NOTE - WE ARE UNABLE TO ACCEPT REFERRALS FOR PATIENTS UNDER 18 YEARS OF AGE**

<p><b>Patient ID</b></p> <p>NHS Number _____</p> <p>First Name _____</p> <p>Surname _____</p> <p>Address _____          _____          _____ Post Code _____</p> <p>Date of Birth _____</p> <p>Telephone (Home) _____</p> <p>Telephone (Work) _____</p> <p>Telephone (Mobile) _____</p> <p>Email Address _____</p> <p>Gender Male <input type="checkbox"/> Female <input type="checkbox"/></p>	<p><b>Referring Clinician</b></p> <p>Name _____</p> <p>GMC/HPC/NMC No. _____</p> <p>Address _____          _____          _____ Post Code _____</p> <p>Referring PCT Code _____</p> <p>Referring Practice Code _____</p> <p>Telephone No. (For urgent clinical findings) _____</p> <p>Fax No. _____</p> <p>NHS Mail (nhs.net only) _____</p>				
<p>Physical/Communication difficulties (Specify if any) _____          _____</p> <p>If interpreter required, language _____</p> <p>Religion _____</p> <p>Ethnicity _____</p>	<p>Eligible for NHS Funded Transport Yes <input type="checkbox"/></p> <p>Car Transport Required Yes <input type="checkbox"/></p> <p>Wheelchair User Yes <input type="checkbox"/></p> <p>The patient must be ambulant, or if a wheelchair user they must be able to transfer independently on to the scanner or examination couch.</p>				
<p><b>Clinical Indication/Problem</b></p> <p>Please provide as much relevant clinical information to ensure the most appropriate investigation is performed.</p>					
<p><b>Allergies:</b></p>					
<p><b>Relevant Past Medical History</b></p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border: none; vertical-align: top;"> <p><b>Cardiac History</b></p> <p><input type="checkbox"/> MI</p> <p><input type="checkbox"/> Angina</p> <p><input type="checkbox"/> Valve Problems</p> <p><input type="checkbox"/> Murmurs</p> <p><input type="checkbox"/> Cardiac Surgery</p> <p><input type="checkbox"/> Atrial Fibrillation</p> <p><input type="checkbox"/> Cardiomyopathy</p> <p><input type="checkbox"/> Other</p> </td> <td style="width: 50%; border: none; vertical-align: top;"> <p><b>Other Significant History</b></p> <p><input type="checkbox"/> Hypertension</p> <p><input type="checkbox"/> Diabetes</p> <p><input type="checkbox"/> Thyroid Disease</p> <p><input type="checkbox"/> Alcohol/Drug Abuse</p> <p><input type="checkbox"/> Chronic Anaemia</p> <p><input type="checkbox"/> COPD</p> <p><input type="checkbox"/> Other</p> </td> </tr> </table>		<p><b>Cardiac History</b></p> <p><input type="checkbox"/> MI</p> <p><input type="checkbox"/> Angina</p> <p><input type="checkbox"/> Valve Problems</p> <p><input type="checkbox"/> Murmurs</p> <p><input type="checkbox"/> Cardiac Surgery</p> <p><input type="checkbox"/> Atrial Fibrillation</p> <p><input type="checkbox"/> Cardiomyopathy</p> <p><input type="checkbox"/> Other</p>	<p><b>Other Significant History</b></p> <p><input type="checkbox"/> Hypertension</p> <p><input type="checkbox"/> Diabetes</p> <p><input type="checkbox"/> Thyroid Disease</p> <p><input type="checkbox"/> Alcohol/Drug Abuse</p> <p><input type="checkbox"/> Chronic Anaemia</p> <p><input type="checkbox"/> COPD</p> <p><input type="checkbox"/> Other</p>		
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<p><b>Is the patient currently taking any of the following medication</b></p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border: none; vertical-align: top;"> <p><input type="checkbox"/> Beta Blockers</p> <p><input type="checkbox"/> Diuretics</p> <p><input type="checkbox"/> Anti-arrhythmics</p> <p><input type="checkbox"/> Anti-hypertensives</p> </td> <td style="width: 50%; border: none; vertical-align: top;"> <p><input type="checkbox"/> Sympathomimetics</p> <p><input type="checkbox"/> Anticoagulants</p> <p><input type="checkbox"/> Other relevant medication</p> </td> </tr> </table>		<p><input type="checkbox"/> Beta Blockers</p> <p><input type="checkbox"/> Diuretics</p> <p><input type="checkbox"/> Anti-arrhythmics</p> <p><input type="checkbox"/> Anti-hypertensives</p>	<p><input type="checkbox"/> Sympathomimetics</p> <p><input type="checkbox"/> Anticoagulants</p> <p><input type="checkbox"/> Other relevant medication</p>		
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<p>Referrer's Signature ..... Date of request ____/____/____</p>					