



Cardiology Outpatient Department Request Form

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Date: Patient Name:

Address:

D.O.B.: Insurance / Self Pay:

Referring Physician: Signature:

Address:

Telephone: Fax:

Please tick boxes below where appropriate

Requested Investigations

- Resting ECG
Exercise Stress test (treadmill)
ECHO
ECHO with Bubble Study
24HR Holter Monitor
48 HR Holter Monitor
Blood Pressure monitor
Pacemaker check
ICD (defibrillator check)
TOE*

(*Cardiologist Consultation required prior to referral for TOE)

Risk factors

- Gender:
BP:
Cholesterol:
Renal function:
Diabetes:
Smoker:
Family history:
Other:

Referral Details:

Multiple horizontal lines for entering referral details.

Medications:

Two horizontal lines for entering medication information.

URGENT

ROUTINE