Ambulatory ECG

KINGSBRIDGE Private Hospital ★★★★★

Patient number

Please Tick ☐ Event/Loop ☐ 24 Hour

Referrers are required to complete sections 1-2 accurately and legibly. Inadequately completed forms will not be accepted.

1. Patient Details

Title		Forename		Surname	
DOB		Gender	☐ Male ☐ Female		
Address				Postcode	
Tel (Home)		Tel (Mobile)			

Patient Identification - For Kingsbridge Private Hospital use only.

I have confirmed the above patient's name, address and DOB.		Signed	
☐ Verified by patient	If another/status	Signed	

Referring Clinician (print name)		Signature		Date	
Address				Postcode	
Email		Tel			

2. Clinical Details

Does patient have any known cardiac disease? ☐ Yes ☐ No

If **yes** please state type of medication:

Is patient on cardiac medication? ☐ Yes ☐ No

If **yes** please state type of medication:

Does patient complain of syncope? ☐ Yes ☐ No

If **yes**:

- ☐ One occasion only
- ☐ Two occasions
- ☐ More than two occasions

If **no**:

☐ Palpitations	*Frequency:*	☐ Daily	☐ 1-2 per week	☐ Weekly	☐ Infrequently
☐ Dizziness	*Frequency:*	☐ Daily	☐ 1-2 per week	☐ Weekly	☐ Infrequently
☐ Angina					
☐ Hypertension					
☐ Arrhythmias	*Duration:*	☐ Daily	☐ 1-2 per week	☐ Weekly	☐ Infrequently
☐ Chest Pain					
☐ SOB					
☐ Pacing					

CP (Print Name)		Signature	
Date device fitted		Date device due back	

Please send completed form by post or email to:
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