Ambulatory Blood Pressure Monitoring

Patient ref number

WLI number

Referrers are required to complete sections 1-3 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 (Mobile)

2. Clinical Details

Height (cm)

Weight (kg)

☐ Diuretic
☐ Beta Blocker
☐ ACE Inhibitor
☐ Alpha Blocker
☐ Other:

Duration of hypertension months

☐ Left ventricular heart failure
☐ Family history
☐ Previous myocardial infraction
☐ ECG
☐ Echocardiogram

Smoker

☐ Non
☐ Ex
☐ Current/Number per day

3. Reason for 24 hour assessment

☐ Hypertension ☐ Hypotension ☐ Poorly controlled ☐ White coat response

☐ Other

CP (Print Name) | Signature

Date device fitted | Date device due back

Please send completed form by post or email to:
Kingsbridge Private Hospital, MRI, CT and Outpatients Centre, 801 - 805 Lisburn Road, Belfast, BT9 7GX.
T: +44 (0) 28 9073 5272 | E: imaging@3fivetwo.com | kingsbridgeprivatehospital.com

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