Ambulatory ECG

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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T: +44 (0) 28 9073 5272 | E: imaging@3fivetwo.com | kingsbridgeprivatehospital.com

ECG Ambulatory