# CCP Supervised Treadmill

KINGSBRIDGE Private Hospital

Patient ref number

**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 | |

I have examined this patient and reviewed the ECG: the patient does **NOT** have aortic stenosis, cardiomyopathy, a serious cardiac arrhythmia or any acute myocardial infarct. It is safe to perform a medically unsupervised treadmill test.

| | | | |
|---|---|---|---|
| Referring Doctor (print name) | | Signed | |
| GP Cypher Code | | | |
| Address | | Postcode | |
| Email | | Tel (Mobile) | |

## 2. Type of treadmill, reason for referral and clinical diagnosis

**Type of treadmill**

☐ Bruce
☐ Modified Bruce

**Reason for test**

☐ Diagnosis of chest pain
☐ Determination of exercise capacity
☐ Provocation of arrhythmias
☐ Other

**Clinical diagnosis**

☐ Suspected coronary heart disease
☐ Proven coronary heart disease
☐ Valvular heart disease
☐ Cardiomyopathy
☐ Acute myocardial infarction
☐ Other

**Heart failure**

☐ Yes
☐ No

Is the patient on any cardiac/hypertensive medication? (if yes, keep on all medication). If yes, please name drugs:

CP (Print Name)

Signature

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