Ambulatory E.C.G.

Patient No. _____

Please tick: Event / loop ☐ 24 hour ☐

3fivetwo™ HEALTHCARE

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

1 Patient Details

Surname: _____ Forename: _____ Title: _____

Date of Birth: _____ Gender: Male / Female (Delete as appropriate)

Address: _____

_____

Post Code: _____ Tel (Home): _____ Mobile: _____

Patient Identification: For 3fivetwo Healthcare use only.

I have confirmed the above patients name, address and DOB. Signed: _____

Verified by patient: ☐ If another / Status: _____ Signed: _____

Referring Clinician (print name): _____ Signature: _____

Address: _____

Post Code: _____ Email Address: _____ Tel: _____

2 Clinical details

Does patient have any known cardiac disease?

☐ Yes / If so please indicate type: _____

☐ No

Is patient on cardiac medication?

☐ Yes / If yes please state type of medication: _____

☐ No

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 ..... ☐ Daily ☐ 1-2 per week ☐ Weekly ☐ Infrequently

☐ Angina

☐ Hypertension

☐ Arrhythmias ..... Duration: ☐ Seconds ☐ Minutes ☐ Hours

☐ Chest pain

☐ SOB

☐ Pacing

C.P. (print name): _____ Signature: _____

Date device fitted: _____ Date device due back: _____

Please send by post or fax to: **3fivetwo Healthcare** Medical Imaging Centre, 6 Lisburn Road, Belfast BT9 6AA **T** +44 (0)28 9073 5266 **F** +44 (0)28 9024 9929 **E** imaging@3fivetwo.com