OneWelbeck Heart Health Invasive Procedure Booking Form

Please complete all sections of the form. By completing this form, you confirm you have consent require to share this information.

PATIENT DETAILS

TITLE:	FORENAME(S):	SURNAME:
DATE OF BIRTH:	GENDER: ☐MALE ☐ FEMALE ☐ OTHER	
RESIDENTIAL ADDRESS:		POSTCODE:
TELEPHONE:	MOBILE:	
EMAIL:		

PROCEDURE(S)

☐20142 Insertion of implantable ECG loop recorder (L3)

☐20143 Removal of implantable ECG loop recorder

☐X3590 Ferinject iron infusion supervision (L3)

☐K5760 Ablation of atrial fibrillation by isolation of the pulmonary veins including cryoablation

☐K5730 Ablation of atrial arrhythmia

☐K5780 Ablation of accessory pathway or selected modification of AV node

☐K5720 Ablation of AV nodal re-entry tachycardia (K5780)

☐K5810 Diagnostic intracardiac electrophysiological study

☐X5020 External cardioversion (DCCV)

☐64302 Trans-esophageal echocardiography (TOE)

☐K1680 Transluminal closure of atrial septal defect (ASD) / patent foramen ovale (PFO)

☐K6000 Single chamber permanent pacemaker insertion

☐K6010 Dual chamber permanent pacemaker insertion

☐K6015 Implantation of biventricular pacemaker

☐K6030 Replacement of generator for intravenous cardiac pacemaker system (without lead change)

☐K6111 Insertion of combined biventricular pacemaker and cardioverter defibrillator (CRT-D)

☐K6100 Insertion of single chamber implantable cardioverter defibrillator (ICD)

☐K6050 Replacement implantable cardioverter defibrillator (ICD), without lead change

☐K6105 Insertion of dual chamber implantable cardioverter defibrillator (ICD)

☐K6115 Insertion of an implantable cardioverter defibrillator with subcutaneous leads (subcutaneous ICD)

☐K080 Removal of pacing system without bypass (including leads)

☐SEDATION ☐L/A ☐GA ☐REGIONAL BLOCK ☐OTHER:

ANAESTHESIST:	ESTIMATED PROCEDURE DURATION:
DATE & TIME OF PROCEDURE:	POSITION ON LIST:
EQUIPMENT REQUIRED:	
Imaging required in Theatre	☐YES ☐ NO
COVID –19 Screening (within 7 working days):	☐YES ☐ NO
Take home medication confirmed and provided:	☐YES ☐ NO
REFERRER NAME:	
ORIGINATING PHYSICIAN (if Heart Health partner):	

DRUG & MEDCIAL HISTORY (tick yes if relevant)

ANTICOAGULANT/ANTIPLATELET	☐YES ☐ NO	RHEUMATOID ARTHRITIS	☐YES ☐ NO
ASPIRIN	☐YES ☐ NO	CARDIOVASULAR PACEMAKER	☐YES ☐ NO
DIABETES – INSULIN/TABLET	☐YES ☐ NO	RESIRATORY	☐YES ☐ NO
ALLERGIES	☐YES ☐ NO	ABILITY TO CONSENT	☐YES ☐ NO
INFECTIVE (HIV/TB/HEPATITIS)	☐YES ☐ NO	MOBILITY PROBLEMS	☐YES ☐ NO
OTHER (PLEASE STATE) :			

EXTRA REQUIREMENTS

WHEELCHAIR ACCESS ☐ DIETARY REQUIREMENTS ☐ YES- SPECIFY:

INTERPRETER REQUIRED: ☐ YES- SPECIFY:

PAYMENT DETAILS (IF KNOWN)

☐ Bill to Patient	☐ Bill to Insurer	☐ Bill to Embassy	☐ Bill to referrer
	INSURANCE COMPANY:	EMBASSY:	AGENCY NAME:
	MEMBERSHIP NO:	LETTER OF GUARANTEE: ☐ (Please attach)	
	AUTHORISATION CODE:		

NAME : SIGNED : DATE :

PROFESSIONAL REG NO:

Please attach the last clinic letter, any relevant test results and any additional documentation to this form and submit to us via one of the following:

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