OneWelbeck Heart Health

OWHH Diagnostic Test Referral Form (OWHH Consultant)

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

PATIENT DETAILS

TITLE: FORENAME(S): SURNAME:

DATE OF BIRTH: GENDER: ☐ Male ☐ Female ☐ Other:

RESIDENTIAL ADDRESS: POSTCODE:

TELEPHONE: MOBILE:

EMAIL:

REFERRAL DETAIL

OneWelbeck Heart Health Diagnostic tests:

☐ **ECG**
Reporting doctor: No preference

☐ **Echocardiography**
Reporting doctor: No preference

☐ **Bubble Saline/Contrast Echocardiography**
Reporting doctor: No preference

☐ **Exercise Tolerance Testing**
Reporting doctor: No preference

☐ **Exercise Stress Echo**
Reporting doctor: No preference

☐ **Dobutamine Stress Echo**
Reporting doctor: No preference

☐ **MVO2/CPEX**
Reporting doctor: No preference

☐ **24 Hour ECG**
Reporting doctor: No preference

☐ **48 Hour ECG**
Reporting doctor: No preference

☐ **72 Hour ECG**
Reporting doctor: No preference

☐ **1 Week Event Recorder**
Reporting doctor: No preference

☐ **24 Hour Blood Pressure Monitor**
Reporting doctor: No preference

☐ **Kardia/Alivecor 1 Month Event recorder**
Reporting doctor: No preference

☐ **Ambulatory Sleep Study (WatchPAT)**
Implanting doctor: No preference

☐ **ILR – Implantable Loop Recorder Check**
Implanting doctor: No preference

☐ **ILR – Implantable Loop Recorder Insertion**
Implanting doctor: No preference

☐ **Permanent Pacemaker Check**
Reporting doctor: No preference

☐ **ICD Check - Implantable Cardioverter Defibrillator**
Reporting doctor: No preference

Pathology:

☐ **Blood Tests - OWHH Profile 1** ☐ **Fasting**

☐ **Additional Blood Tests (please specify):**

Information/Instruction to be passed to personnel conducting test:

☐ **Follow up consultation on completion of tests (OneWelbeck only)**

CLINICAL INDICATION

☐ Chest Pain
☐ Shortness of Breath on Exertion
☐ Hypertension
☐ Palpitations
☐ Syncope
☐ Other (Please Specify):

OTHER REQUESTS

☐ Iron Infusion

PAYMENT DETAILS (IF KNOWN)

TYPE: Self-funding ☐ Insured ☐ Embassy ☐ Other (please complete below sections as appropriate)

INSURANCE COMPANY: MEMBERSHIP NO: AUTHORISATION CODE:

EMBASSY: LETTER OF GUARANTEE: ☐ Yes (please attach)

EXTRA REQUIREMENTS

SPECIAL EQUIPMENT REQUIREMENTS: WHEELCHAIR ACCESS: ☐

INTERPRETER REQUIRED: ☐ Yes, please confirm language:

OTHER:

DECLARATION & FORM SUBMISSION

I authorise this patient to undergo the above order.

NAME: SIGNED: DATE:

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

E: bookings.hearthealth@onewelbeck.com
A: Bookings, OneWelbeck Heart Health, 1 Welbeck Street London W1G 0AR
T: +44 (0)203 653 2005