

# 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: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other:	
RESIDENTIAL ADDRESS:		POSTCODE:
TELEPHONE:	MOBILE:	
EMAIL:		

## REFERRAL DETAIL

### OneWelbeck Heart Health Diagnostic tests:

<input type="checkbox"/> <b>ECG</b> Reporting doctor: <input type="checkbox"/> <b>Echocardiography</b> Reporting doctor: <input type="checkbox"/> <b>Bubble Saline/Contrast Echocardiography</b> Reporting doctor: <input type="checkbox"/> <b>Exercise Tolerance Testing</b> Reporting doctor: <input type="checkbox"/> <b>Exercise Stress Echo</b> Reporting doctor: <input type="checkbox"/> <b>Dobutamine Stress Echo</b> Reporting doctor: <input type="checkbox"/> <b>MVO2/CPEX</b> Reporting doctor: <input type="checkbox"/> <b>24 Hour ECG</b> Reporting doctor: <input type="checkbox"/> <b>48 Hour ECG</b> Reporting doctor: <input type="checkbox"/> <b>72 Hour ECG</b> Reporting doctor: <input type="checkbox"/> <b>1 Week Event Recorder</b> Reporting doctor: <input type="checkbox"/> <b>24 Hour Blood Pressure Monitor</b> Reporting doctor: <input type="checkbox"/> <b>Kardia/Alivecor 1 Month Event recorder</b> Reporting doctor:	<input type="checkbox"/> <b>Ambulatory Sleep Study (WatchPAT)</b> Implanting doctor: <input type="checkbox"/> <b>ILR – Implantable Loop Recorder Check</b> Implanting doctor: <input type="checkbox"/> <b>ILR – Implantable Loop Recorder Insertion</b> Implanting doctor: <input type="checkbox"/> <b>Permanent Pacemaker Check</b> Reporting doctor: <input type="checkbox"/> <b>ICD Check - Implantable Cardioverter Defibrillator</b> Reporting doctor:  <b>Pathology:</b> <input type="checkbox"/> <b>Blood Tests - OWHH Profile 1</b> <input type="checkbox"/> <b>Fasting</b> <input type="checkbox"/> <b>Additional Blood Tests (please specify):</b>  Information/Instruction to be passed to personnel conducting test:  <input type="checkbox"/> <b>Follow up consultation on completion of tests (OneWelbeck only)</b>
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## 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: <input type="checkbox"/> 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:
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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