

REQUEST FOR CARDIOVASCULAR INVESTIGATION

Patient Name: Outpatient
 Patient Address: In-Patient Room:

 Contact Tel:

Relevant History & Medication:

INVESTIGATIONS REQUIRED (PLEASE TICK BOXES)

Chest X-ray P-A Lateral

Resting 12-lead ECG <input type="checkbox"/>	Exercise ECG Stress Test:
Ambulatory ECG Monitoring:	Bruce Protocol <input type="checkbox"/>
24 hrs <input type="checkbox"/>	Modified Bruce Protocol <input type="checkbox"/>
48 hrs <input type="checkbox"/>	Pacemaker Check <input type="checkbox"/>
Event Recorder weeks <input type="checkbox"/>	ICD Check <input type="checkbox"/>
Other Examinations <input type="checkbox"/>	Ambulatory 24 hr BP Monitoring <input type="checkbox"/>
Does Patient have: Pacemaker? Yes <input type="checkbox"/> No <input type="checkbox"/>	Tilt Table Test <input type="checkbox"/>
ICD? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Is Cardiologist's report required? Yes <input type="checkbox"/> No <input type="checkbox"/>	

Transthoracic Echocardiogram Carotid Doppler
 Stress Echocardiogram

Requested by Dr / Mr / Miss:
 Address:
 Telephone: Fax:
 Doctor's Signature: Date:

If possible give report to Patient Fax report to

(Unless specially requested, echo reports are sent out next day)

Guidance Notes for Referrers for Chest Xray

In accordance with the requirements of **Ionising Radiation (Medical Exposures) Regulations 2000**, the referrer's attention is drawn to the following protocols in use at The Harley Street Clinic.

Referrals:

- A request for a radiological examination will be regarded as a request from one clinician or health professional to the Imaging Department for an opinion, based upon a radiological examination, to assist in the management of a clinical problem.
- Diagnostic imaging or radiological procedures will only be performed upon written request signed by a registered medical or dental practitioner or by an authorised non-medical practitioner.
- Referrals (request form or letter) must precede or accompany the patient, Faxes are accepted.
- All requests must carry sufficient information to identify the patient, normally consisting of first name, middle name if any, family name, date of birth and address.
- All requests must carry sufficient clinical information to enable the requested examination to be justified. Referral criteria are based on the Royal College of Radiologist's Guidelines - *"Making the best use of a Department of Clinical Radiology: Guidelines for Doctors"*.
- All requests shall clearly state the examination requested.
- All requests must include contact details of the referring clinician including address and telephone number.

Females of Childbearing age (12 - 55 yrs)

- All requests for X-rays, CT and Nuclear medicine examinations (between the diaphragm and the knee) of females of childbearing age (12-55yrs) must state the date of the first day of the patient's last menstrual period.

Clinical Justifications of Requests

- All requests for imaging will be assessed **prior to exposure** by the appropriate practitioner for the examination to ensure that they meet with the Royal College of Radiologist's Guidelines and any local guidelines and that in their professional judgement they are clinically justified (*Royal College of Radiologist Publications: BFCR (00)5*).

IMAGING DEPARTMENT USE ONLY

Examination Justified & Authorised by
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Females of Childbearing Age (12-55 yrs) - declaration to be completed by the patient and operator

Is there any possibility that you might be pregnant? _____

Signed (patient): _____ **Date:** / / **Signed** (operator): _____

Radiographer (Signature)	Radiologist (Signature)
Exam Room(s)	

	Time	Date	Signed
Contrast Given			
Reaction			
Other IV meds given			

Exposure Records

View	kVP	mAs	FFD	View	kVP	mAs	FFD

Programme	Screening Time	DAP reading	No. of Digital Images
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Film Usage

Size	Passed	Reject	Size	Passed	Reject	Comment
18 x 24			35 x 35			
24 x 30			35 x 43			
30 x 40			18 x 43			
Laser			Other			