

Ambulatory Blood Pressure Monitoring



Patient Ref No. _____

Referrers are required to complete sections 1-3 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: _____ Date: _____

Address: _____

Post Code: _____ Email Address: _____ Tel: _____

2 Clinical details

_____ Height (cm) _____ Weight (kg) _____ BSA _____

Drugs:

- Diuretic
- Beta Blocker
- ACE Inhibitor
- Alpha Blocker
- Other _____

Duration of hypertension: _____ months

Smoker:

- Non
- Ex
- Current / Number per day: _____

Left Ventricular Heart Failure

Family history

Previous myocardial infarction

E.C.G.

Echocardiogram

3 Reason for 24 hour assessment

Hypertension Hypotension Poorly controlled White coat response

Other _____

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 9066 4352 F +44 (0)28 9024 9929 E imaging@3fivetwo.com

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AMBULATORY