Ambulatory E.C.G.

Patient No. ___________________________

Please tick: Event / loop ☐ 24 hour ☐

Referrers are required to complete sections 1-2 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: ___________________

Address: ____

Post Code: __________ Email Address: ___________________ Tel: ___________________

2 Clinical details

Does patient have any known cardiac disease?

☐ Yes / If so please indicate type: ___________________________

☐ No

Is patient on cardiac medication?

☐ Yes / If yes please state type of medication: ___________________________

☐ No

Does patient complain of syncope?

☐ Yes

☐ No

If yes:

☐ One occasion only

☐ Two occasions

☐ More than two occasions

If no:

☐ Palpitations ....

☐ Dizziness ....

☐ Angina

☐ Hypertension

☐ Arrhythmias ....

☐ Chest pain

☐ SOB

☐ Pacing

Frequency:

☐ Daily ☐ 1-2 per week ☐ Weekly ☐ Infrequently

☐ Daily ☐ 1-2 per week ☐ Weekly ☐ Infrequently

Duration:

☐ Seconds ☐ Minutes ☐ Hours

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

ECG AMBULATORY