

C.C.P. Supervised Treadmill



Patient Ref No. _____

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: _____

I have examined this patient and reviewed the ECG: the patient does **NOT** have aortic stenosis, cardiomyopathy, a serious cardiac arrhythmia or any acute myocardial infarct. It is safe to perform a medically unsupervised treadmill test.

Referrer (print name): _____ Signature: _____

Address: _____

Post Code: _____ Email Address: _____ Tel: _____

2 Type of treadmill, reason for referral and clinical diagnosis

Type of treadmill:

- Bruce
 Modified Bruce

Reason for test:

- Diagnosis of chest pain
 Determination of exercise capacity

- Provocation of arrhythmias
 Other / Please state: _____

Clinical diagnosis:

- Suspected coronary heart disease
 Proven coronary heart disease

- Valvular heart disease
 Cardiomyopathy

- Acute myocardial infarction
 Other / Please state: _____

Heart failure:

- Yes No

- Is the patient on any cardiac/hypertensive medication? (if yes, keep on all medication)

If yes, please name drugs: _____

C.P. (print name): _____ Signature: _____

Date device fitted: _____ Date device due back: _____