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: ____________________

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