**Please fill in this form as completely as you can, as it makes the testing process safer**

If you require clarification or guidance for completing this form please email Dr Rob Stephens (UCLH) on

ucl-tr.CPXref@nhs.net

**Telephone Number: 020 7679 5076**

**Completed forms should also be sent to the above email address**

**PATIENT DETAILS**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Name** |  | **DOB** |  | **Hospital Number**  |  |
| **Address**  |  | **Telephone number** | **HOME** |  |
| **Email** |  | **MOBILE** |  |

**REFERRING PHYSICIAN**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Name** |  | **Department** |  | **Hospital** |  |
| **Name &****Address for Reports** |  | **Contact Telephone number** |  |
| **Email** |  |

**FINANCE DETAILS**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Name** |  | **Department** |  | **Hospital** |  |
| **Address for invoice** |  | **Contact Telephone number** |  |
| **Email** |  |

**PURCHASE ORDER DETAILS**

|  |  |  |  |
| --- | --- | --- | --- |
| **PO number** |  | **Raised by** |  |

**REASON FOR TEST - please place an X in the appropriate test box and fill in additional information**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Pre Op** |  | **Date of surgery** |  | **Surgical Procedure:** |  |

**MEDICAL HISTORY**

|  |
| --- |
| **MEDICATIONS - Please give details of all medications** |
|  |

**PLEASE NOTE THAT DUE TO WEIGHT RESTRICTIONS ON OUR EQUIPMENT WE ARE UNABLE TO TEST PATIENTS WHO WEIGH OVER 180KG**

|  |  |
| --- | --- |
| **MOBILITY** | **Y / N** |
| ABLE TO WALK |  |
| WALKS WITH STICK |  |
| REQUIRES WHEEL CHAIR BUT HAS LIMITED MOBILITY |  |
| PERMANENTLY WHEEL CHAIR BOUND |  |
| ABLE TO CYCLE ON AN EXERCISE BIKE? |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **CARDIOVASCULAR HISTORY** | **Y / N** | **Delete/highlight** **as applicable** | **Specific information AND date** |
| MYOCARDIAL INFARCTION |  |  |   |
| ANGINA |  |  |  |
| CORONARY STENT (ANGIOPLASTY) |  |  |   |
| CABG |    |  |   |
| HYPERTENSION |    |  |   |
| CARDIAC FAILURE |    |  |   |
| PERIPHERAL VASCULAR DISEASE |   |  |   |
| STROKE - CVA OR TIA |    |  |   |
| DIABETES |  |  |   |
| VALVULAR HEART DISEASE |  |  |  |
| ARRYTHMIAS/RHYTHM DISORDERS |  |  |  |
| INHERITED HEART DISEASES  |   |  |  |
| **RESPIRATORY HISTORY** |  |
| COPD / ASTHMA |  |  |   |
| PULMONARY EMBOLUS |    |  |   |
| PULMONARY HYPERTENSION |  |  |   |
| PULMONARY FIBROSIS |    |  |   |
| SMOKER |   |   |   |
| **MUSCULOSKELETAL** |  |
| ARTHRITIS |  |  |  |

|  |
| --- |
| **ADDITIONAL DETAILS**Please include any additional relevant past medical history or investigations (e.g. chemotherapy, previous surgeries, electrocardiogram, lung function, echocardiogram etc |
|  |