heartsure

Cardiology Clinic & Diagnostic Service

Referral Form – Cardiology Consultations

Please email this form to info@heartsure.co.uk

Section 1 – PATIENT INFORMATION		
Surname:		Home Tel:
First Name:		Mobile Tel:
Title:	Gender:	Email:
Date of Birth:		Next of Kin:
Address:		NOK Contact:
		Postcode:

Section 2 – PRACTICE / CLINIC INFORMATION	
Referring Clinician:	Date of Referral:
Practice Phone:	Practice Email:
Practice Name:	
Practice Address: Postcode:	

Section 2a – CLINICIAN CATEGORY							(please tick)
GP:		Consultant:		Healthcare Professional:		Other:	

Section 3 – BILLING INFORMATION CATEGORY		
Self-Funding		Please proceed to section 4
Private Health Insurance		Please complete below
Insurance Provider Name:		
Policy / Membership Number:		
Pre-Authorisation Code / Claim Reference:		

Clinic Requirements									
General		Arrhythmia		Heart Failure		Angina		Other	

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Section 4 – CLINICAL INFORMATION	
Main Symptoms / Presenting Complaints:	
Date of Onset / Duration:	

Risk Factors:									
Hypertension		Diabetes		Smoking		High Cholesterol		Other	
Please Specify:									

Past Medical History:	
Family History	
Current Medications	
Additional Details & Special Requirements	

Section 5 – Confirmation			
I confirm that the details provided on this form are correct and accurate to the best of my knowledge. Heartsure will be informed immediately if any errors are made.			
Signed		Date	