Echocardiography Request Form



Please complete all known information on this form and email to <u>CCLREFERRALS@ccf.org</u> or fax to 0207 890 4466 For referral appointments by telephone please call our dedicated Referrals Line on 0203 423 7777

Patient Details	Referrer Details	
Title:	Name:	
Surname:	Practice name:	
First name:	Street address:	
Sex:	Postcode:	
Date of birth (DD/MM/YYYY):	Telephone No.:	
NHS No. (If known):	Email:	
Street address:	Payment Details	
Postcode:		
Telephone/ Mobile:	Private Health insurance Embassy patient Self-Funding	
Email:		

Clinical information			
Indication for test:			
Does the patient have symptoms? Yes			
If yes, please describe			
Previous cardiac history:			
Patient weight (kg):	Patient height (cm):		
Does the patient have any allergies? Yes	No		
If yes, please describe			
Are there any accessibility / mobility concerns? Yes No			
If yes, please describe			
When is the test required? 24 hours 1 - 3	days 🗌 1 - 2 weeks 🗌 Other:		
If you would like to discuss this referral with a cardiology consultant or senior cardiac physiologist, please phone 0203 423 7102.			
Test required			
Standard transthoracic echocardiogram with clinical comment			
Murmur / Suspected valve disease	Atrial Fibrillation		
Palpitations	Hypertension		
Abnormal ECG	Chest pain / coronary disease		
Suspected heart failure symptoms / elevated BNP	Other - please outline in clinical information above		
Shortness of breath			

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Test required

Transthoracic echocardiogram with cardiology consultation

Includes a comprehensive transthoracic echocardiogram (TTE), clinical review and opinion - a management plan will be communicated to the referrer. Follow up or onward referral can be arranged, according to referrer preference.

Please provide clinical details in the relevant sections above.

Stress echocardiogram (exercise or dobutar	nine)			
Does the patient take beta blockers?	Yes*	🗌 No	*If yes, we advise patients to stop these 48 hours prior to the test	
Can the patient walk / jog on a treadmill?	Yes	🗌 No		
Can the patient use a static bicycle?	Yes	🗌 No		
Does the patient have a pacemaker / defibrillator?	Yes	🗌 No		
Does the patient have a contrast allergy?	Yes	🗌 No		
Transoesophageal echocardiogram				
We require a transthoracic echocardiogram (TTE) pr	rior to a transoesoph	nageal echocardio	gram (TOE). You can request a TTE using this form.	
Has the patient had a standard transthoracic echocardiogram? Yes No				
If yes, please advise where this was performed so that we can organise the transfer of the images:				
What are the sedation requirements? Sedation General Anaesthetic				
Thank you for your referral. If the echocardiogram is	s abnormal, would ye	ou like a cardiolog	gist at Cleveland Clinic London to review the patient?	
Yes No				
Preferred route for results: Email	Telephone	Post		
Contact telephone number for communication of urgent findings:				

Additional information		
Contraindications to stress echocardiography Severe aortic stenosis Poorly controlled hypertension Unstable angina Recent myocardial infarction Severe pulmonary hypertension High risk of ventricular arrhythmias 	Cautions and contraindications to transoesophageal echocardiography Oesophageal stricture or tumour Oesophageal perforation of laceration Oesophageal diverticulum Active upper Gl bleed Loose, unstable teeth 	