# C.C.P. Supervised Treadmill

KINGSBRIDGE Private Hospital

| Patient ref number: | |
|---|---|

**Referrers are required to complete sections 1-2 accurately and legibly. Inadequately completed forms will not be accepted.**

## 1 - Patient Details

| | | | | | |
|---|---|---|---|---|---|
| Title: | | Forename: | | Surname: | |
| DOB: | | Gender: ☐ Male ☐ Female | | | |
| Address: | | | | | |
| Postcode: | | Tel (Home): | | Mobile: | |

| **Patient Identification** For Kingsbridge Private Hospital use only. | I have confirmed the above patient's 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.

| | | | | | |
|---|---|---|---|---|---|
| Referring Doctor (print name): | | | | Signature: | |
| GP Cypher Code: | | | | | |
| Address: | | | | | |
| Post Code: | | Email: | | 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:

**Clinical diagnosis:**

- ☐ Suspected coronary heart disease
- ☐ Proven coronary heart disease
- ☐ Valvular heart disease
- ☐ Cardiomyopathy
- ☐ Acute myocardial infarction
- ☐ Other:

**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: | |
|---|---|---|---|

**Please send completed form by post, fax or email to:**

**Kingsbridge Private Hospital**, MRI, CT and Outpatients Centre, 801 - 805 Lisburn Road, Belfast, BT9 7GX.
T: +44 (0) 28 9073 5272 | F: +44 (0) 28 9024 9929 | E: imaging@3fivetwo.com