

Investigation Clinic Referral

If you would like to refer a patient, please complete the details below.
 This can either be faxed back on **01494 867 636** or sent to **Chiltern Hills Heart Clinic, at the address above.**

Patient Name:

Date of Birth:

Daytime Tel. No.:

Evening Tel. No.:

Address:

Requesting Doctor:

Requesting Doctor's Tel. No.:

Requesting Doctor's Address:

GP: (if not requested)

Clinical Details: (including relevant previous medical history)

Specify Investigations Required:

If patient should stop medication for test please specify drug:

Does the patient require a consultation with Dr Ramrakha, Consultant Cardiologist?

Yes

No

Does the patient have private medical insurance?

Yes

No

Name of insurer

Signature of Referring Doctor:

Date and time of test: (office use only)

NP

FU