ST. MICHAEL'S HOSPITAL
Dún Laoghaire

Referring Doctor: .....

Doctors Name: .....

Address: .....

.....

Phone: .....

Fax: .....

CARDIAC DEPARTMENT

Ph: 01 663 9895 • Fax: 01 271 3026

AMBULATORY BP MONITOR

Incomplete forms are a contra-indication and will not be accepted.
Incomplete forms will be returned and hence cause delay.

Diagnosis and Reason for Test	Name	MRN
	Address:	
	Pt's Mobile/Phone:	
	Age/D.O.B.	Sex
	Dr	Ward/OPD
The test will not be performed without stated reason	Date	Signed

Patient will be forwarded an appointment by post

CURRENT MEDICATION - Must be included

B-Blocker Yes ❑ No ❑

Digoxin Yes ❑ No ❑

Other Relevant Meds: Yes ❑ No ❑

Please Specify: .....

MEDICAL CONSENT

Signed: Dr. .....

Bleep # .....

Consultant ❑ Registrar ❑

GP ❑ SHO ❑ Intern ❑

Date: .....