ST. MICHAEL'S HOSPITAL
Dún Laoghaire

CARDIAC DEPARTMENT
Ph: 01 663 9895 • Fax: 01 271 3026

ECG CLINIC

Referring Doctor: .....

Doctors Name: .....

Address: .....

.....

Phone: .....

Fax: .....

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	

ECG Clinic

Please give completed form to patient to book appontment by phone 01 663 9895.
DO NOT fax or post.
The patient is responsible to make the appointment

CURRENT MEDICATION - Must be included

B-Blocker	Yes ❑ No ❑	Other Relevant Meds:	Yes ❑ No ❑
Digoxin	Yes ❑ No ❑	Please Specify:	

MEDICAL CONSENT

Signed: Dr. ..... Consultant ❑ Registrar ❑ GP ❑ SHO ❑ Intern ❑

Bleep # ..... Date: .....