ST. MICHAEL'S HOSPITAL
Dún Laoghaire

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

HOLTER MONITOR

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

Patient will be forwarded an appointment by post

CURRENT MEDICATION - Must be included

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

MEDICAL CONSENT

Consultant ❑ Registrar ❑

Signed: Dr. ..... GP ❑ SHO ❑ Intern ❑

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