ST. MICHAEL'S HOSPITAL
Dún Laoghaire

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

Referring Doctor: _____

Doctors Name: _____

Address: _____

_____

Phone: _____

Fax: _____

ECG CLINIC

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./Mr.	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

Consultant ❑ Registrar ❑

Signed: Dr. ..... GP ❑ SHO ❑ Intern ❑

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

Please e-mail the completed form to the cardiology clinic in St Michael Hospital
cardiologyclinic@stmichaels.ie