



**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./Mr.	Ward/OPD	
	The test will not be performed without slated reason	Date	Signed

Patient will be forwarded an appointment by post

CURRENT MEDICATION - Must be included

B-Blocker	Yes <input type="checkbox"/> No <input type="checkbox"/>	Other Relevant Meds:	Yes <input type="checkbox"/> No <input type="checkbox"/>
Digoxin	Yes <input type="checkbox"/> No <input type="checkbox"/>	Please Specify:	

MEDICAL CONSENT

Signed: Dr.	Consultant <input type="checkbox"/>	Registrar <input type="checkbox"/>
Bleep #	GP <input type="checkbox"/>	SHO <input type="checkbox"/> Intern <input type="checkbox"/>
	Date:	

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