Spire
Roding Hospital

Referral form for Cardiac Services

Referring Consultant	
Date of Referral	
Time	
First name(s)	
Surname	
Date of birth	
Address	
Post code	
Home telephone	
Office telephone	
Mobile	

Examination required

Please specify which test & tick appropriate box

Echocardiogram* ☐ (*book on Cardiac Testing Clinic) 24 Hour BP ☐ (book on Cardiac Monitoring Clinic)

24hr ECG Monitoring ☐ (book on Cardiac Monitoring Clinic) 7 Day ECG Monitoring ☐ (book on Cardiac Monitoring Clinic)

14 Day ECG Monitoring ☐ (book on Cardiac Monitoring Clinic)

Current Medication	
Reason for investigation:	
Blood pressure	
Resting ECG findings	
Date of follow up appointment:	

Tel: 020 8709 7878
Email:outpatrd@spirehealthcare.com
Fax: 020 8709 7877

Looking after you.