CCP Supervised Treadmill

KINGSBRIDGE Private Hospital

Patient ref number

Referrers are required to complete sections 1-2 accurately and legibly. Inadequately completed forms will not be accepted.

1. Patient Details

Title		Forename		Surname	
DOB		Gender	☐ Male ☐ Female		
Address				Postcode	
Tel (Home)		Tel (Mobile)			

Patient Identification - For Kingsbridge Private Hospital use only.

I have confirmed the above patient's name, address and DOB.		Signed	
☐ Verified by patient	If another/status	Signed	

I have examined this patient and reviewed the ECG: the patient does **NOT** have aortic stenosis, cardiomyopathy, a serious cardiac arrhythmia or any acute myocardial infarct. It is safe to perform a medically unsupervised treadmill test.

Referring Doctor (print name)		Signed	
GP Cypher Code			
Address		Postcode	
Email		Tel (Mobile)	

2. Type of treadmill, reason for referral and clinical diagnosis

Type of treadmill

- ☐ Bruce
- ☐ Modified Bruce

Reason for test

- ☐ Diagnosis of chest pain
- ☐ Determination of exercise capacity
- ☐ Provocation of arrhythmias
- ☐ Other

Clinical diagnosis

- ☐ Suspected coronary heart disease
- ☐ Proven coronary heart disease
- ☐ Valvular heart disease
- ☐ Cardiomyopathy
- ☐ Acute myocardial infarction
- ☐ Other

Heart failure

- ☐ Yes
- ☐ No

Is the patient on any cardiac/hypertensive medication? (if yes, keep on all medication). If yes, please name drugs:

CP (Print Name) | Signature

Please send completed form by post or email to:
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