

EXERCISE STRESS TEST BOOKING FORM

Name: _____

Date of Birth: _____

Address: _____

Contact No: _____

This form must be completed and must accompany the patient (or faxed in advance) in order for an exercise stress test to be performed.

Indication for test/ Relevant Medical

Information:

Current Medications:

THE FOLLOWING ARE CONTRA-INDICATIONS FOR EXERCISE STRESS TEST:

- Severe angina/rest angina
- Angina < 1 month post-MI, angina post-PTCA/stent, post –CABG
- Known left main stem stenosis
- Moderate – severe aortic stenosis/hypertrophic obstructive cardiomyopathy
- Hypotension eg: SBP <90 mmHg
- Uncontrolled raised BP eg: SBP >180 mmHg; DBP >100 mmHg
- History of ventricular arrhythmias
- LBBB on ECG, ventricular paced.

GP CERTIFICATION:

I CERTIFY THAT THE ABOVE PATIENT IS SUITABLE FOR EXERCISE STRESS TESTING.

GP Signature: _____

Date: _____

GP Printed Name: _____

IF YOU HAVE ANY QUERIES REGARDING THE ABOVE, PLEASE CONTACT THE
CARDIOLOGY DEPARTMENT TEL: 01-2938689 FAX: 01-2936653