



GP Referral Form for Exercise Stress Testing

Fax request to (01) 414 3052

GP Name Address GP Tel: GP Fax:	Request date: Patient Name Address Hosp Number: Tel: DOB:
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Symptoms	√ or X	Med Hx	√ or X	Risk Factors	√ or X
Chest discomfort / Pain	<input type="checkbox"/>	Angina	<input type="checkbox"/>	↑ BP	<input type="checkbox"/>
Dyspnoea	<input type="checkbox"/>	MI		↑ Lipids	<input type="checkbox"/>
Can exercise despite symptoms?	<input type="checkbox"/>	CABG		DM	<input type="checkbox"/>
Asymptomatic	<input type="checkbox"/>	CVA		Smoker	<input type="checkbox"/>
	<input type="checkbox"/>	Nil		Fam Hx CAD	<input type="checkbox"/>
				Nil	<input type="checkbox"/>
Relevant Cardiac Medications		B Blocker	<input type="checkbox"/>		
		Digoxin	<input type="checkbox"/>		
		Others	<input type="checkbox"/>		
		Nil	<input type="checkbox"/>		

Absolute Contraindications to Exercise Testing:

SUSPICION OF OR KNOWN AORTIC STENOSIS
RECENT CHEST INFECTION / SEPSIS
UNSTABLE ANGINA
SUDDEN COLLAPSE OF UNKNOWN CAUSE

Relative Contraindications to Exercise Testing:

Known Left bundle branch block (LBBB)
Very poor exercise tolerance

In my opinion, I am happy to proceed with Exercise testing:

GP Please sign:

Result:		Date of test	<input style="width: 100%;" type="text"/>
Duration	<input style="width: 50px; height: 20px;" type="text"/>	Workload	<input style="width: 50px; height: 20px;" type="text"/>
Positive	<input type="checkbox"/>	High	<input type="checkbox"/>
Negative	<input type="checkbox"/>	Medium	<input type="checkbox"/>
Inconclusive	<input type="checkbox"/>	Low	<input type="checkbox"/>
Response			<input style="width: 50px; height: 20px;" type="text"/>
Chest pain	<input type="checkbox"/>		<input type="checkbox"/>
Arrhythmia	<input type="checkbox"/>		<input type="checkbox"/>
Hypertensive	<input type="checkbox"/>		<input type="checkbox"/>
Asymptomatic	<input type="checkbox"/>		<input type="checkbox"/>
Recommended Action for GP:	<i>Please ring:</i>		
Consider other cause of chest pain	Yes	No	<input type="checkbox"/>
Risk Factor management	Yes	No	<input type="checkbox"/>
Refer to Cardiology OPD	Yes	No	<input type="checkbox"/>
Initiated at hospital by Registrar:	Yes	No	<input type="checkbox"/>
Accepted for Urgent Cardiology Out patients	Yes	No	<input type="checkbox"/>
Accepted for Coronary Angiography	Yes	No	<input type="checkbox"/>
Signature of reporting Registrar	Date		