Echocardiogram

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	

Referring Clinician (print name)		Signature		Date	
Address				Postcode	
Email		Tel			

2. Clinical Diagnosis and Reason for Request

ECG Report

Chest X-Ray Report

CP (Print Name)		Signature	
Date device fitted		Date device due back	

Please send completed form by post or email to:
Kingsbridge Private Hospital, MRI, CT and Outpatients Centre, 801 - 805 Lisburn Road, Belfast, BT9 7GX.
T: +44 (0) 28 9073 5272 | E: imaging@kingsbridgehealthcaregroup.com | kingsbridgeprivatehospital.com

Echo