



**Queensland
Government**

Central Queensland Hospital and Health Service

**Gladstone Hospital
Clinical Measurements
Referral Form**

Facility / Unit:

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Phone:

Date of birth:

Sex: M F I

Gladstone Hospital, Clinical Measurements Unit

Phone: 4976 3207

Fax: 49763232

Referral Source:

ED: Will return to the GP for follow-up

Will return to OPD for review of the test results and ongoing management

TO: **Clinical Measurements – Dr Nona**

Test to be performed as: Inpatient Outpatient in__ weeks Routine Outpatient

External Medical Practice:

(please write name of practice here)

Proposed Urgency

Routine Semi-Urgent (> 14 days) Urgent (< 14 Days)

(If urgent, please provide sufficient history)

Cardiac

ECG

Exercise ECG/ stress ECG

Respiratory

Spirometry

Reversability

*NB * Exercise ECG request, ECG and questionnaire will be reviewed by Physician and Senior Clinician and appointments will be arranged.*

Relevant Medical History & Examination Findings:

Allergies _____

Tobacco

Alcohol

Other Drugs _____

(Incl illicit drugs) _____

Current medications
(including complimentary)

tick if not on any medications

WEIGHTkgs

Recent Investigations Performed:

Please attach recent ECG

Please send copy of report to Dr:

Surgery:

Requesting Doctor:

Provider Number:

Signature (Mandatory): _____

Date of Referral: ____/____/____ (Mandatory)

Office Use Only

Referral Received

____/____/____

Return to doctor for more info:

Appointment

____/____/____

At: ____:____ hrs

Recent Review by Dr:

Change in Appointment

____/____/____

At: ____:____ hrs

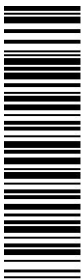
Signature:

Date: ____/____/____

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Printed Locally



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Gladstone Hospital Clinical Measurements Referral

Family name:	Given Name (s):.....	URN:
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Exercise Stress Test Questionnaire

• **What is the clinical purpose for doing this test?**

Diagnostic – β -blockers, nitrates, and high dose Ca⁺⁺ antagonists should be ceased for this test
 A diagnostic Test is performed Off Medications to identify signs of ischaemia when the heart is under Maximum HR / BP load. It is the M.O.'s decision if medications are to be ceased for the test.

Medications usually ceased are:

β -blockers	- ceased 48 hours
Nitrates	- day of test
Digoxin	- one full week (if clinically acceptable)
Ca ⁺⁺ antagonists	- one day

Prognostic – Assess cardiac function on current level of management (*continue medications*)

Arrhythmia detection (*continue medications*)

• **Pre-test probability of angina?**

High Medium Low

• **Patient's current medications**

Please Note: Record current medications with dosage on the reverse side of this form.
 Without this information, we will not be able to proceed with this request

• **Does your patient have any of the following?**
 (Please tick one box. All this section must be completed)

	Yes	No	Don't Know
Unstable Angina with rest pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Myocardial Infarct (< 5 days)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Untreated life-threatening cardiac arrhythmias	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Uncompensated congestive cardiac failure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Second or third degree A-V block	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Acute myocarditis / pericarditis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Aortic stenosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hypertrophic obstructive cardiomyopathy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Uncontrolled hypertension (resting SBP > 160, DBP > 95)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Presence of left bundle branch block	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intercurrent hyperthyroidism, acute infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Severe anaemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Known or suspected left main stem coronary artery disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

• **Patient's risk factors for coronary artery disease**

Family history	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Smoker	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hypertension	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No
High Cholesterol	<input type="checkbox"/> Yes	<input type="checkbox"/> No			

• **Are there any disabilities that will limit the patient from exercising on a treadmill?**

Yes No Please describe: _____

• **Please include a copy of current ECG. This is very important.**

PLEASE FAX THIS FORM WITH THE REFERRAL TO 49763232

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