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.*

Allergies _____

_____

☐ Tobacco

☐ Alcohol

☐ Other Drugs _____

(Incl illicit drugs) _____

Current medications
(including complimentary)

☐ tick if not on any medications

Relevant Medical History & Examination Findings:

WEIGHT ……..kgs

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: _____/_____/_____

CQ487
v1.0-06/2024
Printed Locally
00141:487

Gladstone Hospital Clinical Measurements Referral

Family name: ……..	Given Name (s):……..	URN: ……..

Exercise Stress Test Questionnaire

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

☐ **Diagnostic** – ß-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:		
	ß-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	☐	☐	☐
Myocardial Infarct (< 5 days)	☐	☐	☐
Untreated life-threatening cardiac arrhythmias	☐	☐	☐
Uncompensated congestive cardiac failure	☐	☐	☐
Second or third degree A-V block	☐	☐	☐
Acute myocarditis / pericarditis	☐	☐	☐
Aortic stenosis	☐	☐	☐
Hypertrophic obstructive cardiomyopathy	☐	☐	☐
Uncontrolled hypertension (resting SBP > 160, DBP > 95)	☐	☐	☐
Presence of left bundle branch block	☐	☐	☐
Intercurrent hyperthyroidism, acute infections	☐	☐	☐
Severe anaemia	☐	☐	☐
Known or suspected left main stem coronary artery disease	☐	☐	☐

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

Family history	☐ Yes	☐ No	Smoker	☐ Yes	☐ No
Hypertension	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No
High Cholesterol	☐ Yes	☐ 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

DO NOT WRITE IN THIS BINDING MARGIN