

CPX BOOKING FORM

REFERRING CONSULTANT CONTACT DETAILS (include fax no. for report)

General Practitioner Contact Details

PATIENT NAME + HOSPITAL ID _____

Patient Address / Hospital Ward and ext number if Inpatient

Patient Phone Number _____

Patient Date of Birth _____

Diagnosis/ Reason for CPX referral _____

Surgical Procedure Scheduled + Date of Surgery (if relevant)

Medical/Surgical History

Details of Recent Relevant Investigations (i.e. ECHO, ECG)

Medications (include chemotherapy) _____

Known Allergies _____

Does the Patient require an interpreter? _____

Method of Payment _____

Name/ position /telephone number/ signature of person completing the form

PLEASE FAX TO THE LONDON CLINIC BOOKINGS TEAM ON 020 7616 7688

Address of testing venue:
Cardiology Department
The London Clinic Outpatient Centre
5 Devonshire Place
W1G 6HE
Tel : 020 7616 7664



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