**The Cardiac Clinic**
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THE CARDIAC CLINIC

# PREOPERATIVE CARDIAC CONSULTATION

SURNAME:.....FIRST NAME: .....

DATE OF BIRTH: ..... PHONE NO: .....

**REFERRAL FOR PREOPERATIVE CARDIOLOGY CONSULTATION**:

Urgent ☐ Semi Urgent ☐ Routine ☐

**ANAESTHETIC CONCERN:**
Type of Operation:.....

Type of Anaesthetic.....

GA: Short / Long

**DATE OF OPERATIO**N: .....

**SURGEON:** .....

**INVESTIGATION REQUESTED**:

Echocardiogram ☐ Holter ☐

Exercise Test ☐ Stress Echocardiogram ☐

**BRIEF HISTORY:**

**PERTINENT CLINICAL FINDINGS:**

**PREVIOUS CARDIAC HISTORY:**

**SIGNED:** ..... DATE: .....

PROVIDER NUMBER**:** .....
Practice Stamp: