The Autonomic Medicine Unit: Request Form

St John & St Elizabeth Hospital

☐ Outpatient ☐ Daycase ☐ Inpatient Hospital Number:

Surname: Forenames:

DOB:. ☐ Male ☐ Female

Address: Postcode:

Tel / Mobile:

☐ Self Paying ☐ Insured ☐ Third Party ☐ Walking ☐ Wheelchair ☐ Bed / Trolley ☐ Hoist

Core Autonomic Investigation(s) requested

Please see guidance notes for referrers overleaf

☐ Autonomic Function Screening Assessment
☐ Plasma Catecholamine Blood Samples
☐ Head Up Tilt ☐ 24 hour ECG Monitoring (Autonomic Protocol)
☐ Autonomic Responses to Liquid Meal
☐ Autonomic Responses to Modified Exercise
☐ 24hour BP Monitoring (Autonomic Protocol)

Specialist Autonomic Investigations(s) requested

☐ Autonomic Responses to Head & Neck Movements
☐ Autonomic Responses to Arm Movements
☐ Plasma Metanephrine Blood Samples
☐ Ganglionic Alpha 3 Acetylcholine Antibodies (GACA)
☐ Autonomic Dysreflexia
☐ Autonomic Responses to Octreotide
☐ Autonomic Responses to Pyridostigmine
☐ Autonomic Responses to Sildenafil
☐ Carotid Sinus Massage
☐ 14 day single channel ambulatory ECG Monitor

**Relative Contraindications to Exercise Testing

☐ Aortic Stenosis / Murmur ☐ LBBB/AF on ECG ☐ Resting Chest Pain ☐ History of Ventricular Arrhythmias
☐ HOCM ☐ Angina <1/12 post MI / PCI / CABG ☐ Patient is below 16 years of age
☐ Pregnant ☐ Problems with mobility (Will patient be able to pedal on the bike?

* Relative Contraindications to Head Up Tilt

(In atrial fibrillation, the accuracy of the beat to beat monitoring may be impaired and this should be taken into consideration when requesting testing)

☐ Patient is below 16 years of age ☐ Recent (within 6 months) MI or stroke / TIA ☐ Resting Chest Pain
☐ Pregnant ☐ Weighs > 45st / 285 kgs ☐ Angina <1/12 post MI/PCI/CABG
☐ A known tight stenosis anywhere (e.g. heart valve, LV outflow obstruction, coronary or carotid / cerebrovascular artery)
☐ Problems with mobility (will patient be able to tolerate standing for up to 45 minutes on the tilt table?)
Details: e.g. arthritis of hip/ knee/ recent surgery

Clinical Information and Reason for Test:

(The latest clinic letter must be sent with the referral)

☐ Chest Pain ☐ Palpitations ☐ Shortness of Breath ☐ Pre-syncope ☐ Syncope ☐ Oedema

**Signature of Referring Clinician:
(please read the Referrer's disclaimer overleaf)

Date of Request:

Address for Results:

Name of Referring Clinician:

Tel: Fax: Mobile:

SS. John and Elizabeth Charity, Registered Charity No: 235822 Version 1 SP3181-01/2022 Review Date: January 2025

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Current Medication / Medication to be stopped for testing

Guidance Notes for Referrers

- Respiratory Investigations will only be performed upon written request signed by a registered medical or dental practitioner or by an authorised non-medical practitioner.
- Referrals (request form or letter) must precede or accompany the patient. Faxes are accepted.
- All requests must carry sufficient information to identify the patient, normally consisting of the first name, middle initial (if any), family name, date of birth and address.
- All requests must carry sufficient clinical information to enable the requested examination to be justified in line with national and local guidelines.
- All requests shall clearly state the examination requested.
- All requests must include the contact details of the referring clinician including address, telephone and fax numbers.

**Referrer's Declaration

By signing the request form you are confirming the following:

- **The correct details have been provided**
- **You have discussed the examination including any intervention**
- **You have taken into account the possibility of pregnancy**
- **There are no known contra-indications to performing the requested examination**
- **You will ensure the examination results are recorded in the patient's records**

For Autonomic & Neurovascular Medicine Unit Use Only:

☐ The patient has been provided with the consent information sheet(s) for the procedure(s)

☐ The patient has given verbal informed consent to the procedure(s)

Name of operator:

Signed:

Date:

Consent for 24 hour Monitoring, Plasma Catecholamine, Metanephrines & GACA

Affix Patient Label

Consent for Autonomic Function Screening Test, Tilt Test, Liquid Meal, Modified Exercise Test, Autonomic Responses to Head and Arm movements

The patient has been provided with the consent information sheet(s) for the procedure(s) ☐

Statement of the patient/person with parental responsibility for patient:

I have read all of the information provided and all of my questions / concerns have been answered. I agree to the procedure(s).

Signed (patient):

Date:

Name (print):

Request Form Check

- ☐ Three Points of ID Checked
- ☐ Previous testing Checked
- ☐ Examination Checked with Patient
- ☐ Protocol Confirmed
- ☐ Pregnancy Status Documented

Consent for Carotid Sinus Massage, Dysreflexia and Autonomic Responses to Octreotide, Pyridostigmine, Sildenafil

You must use Hospital Consent Form 3 or 4. Please refer to the Hospital Consent Policy for further guidance.