|  |  |  |  |
| --- | --- | --- | --- |
| *Date & Time of Test :* | *Test Number :* | *MTO :*  | *Date Received :*  |

**DEPARTMENT OF CLINICAL NEUROPHYSIOLOGY**

 **OPD Area 1, The Queen Elizabeth Hospital Birmingham, Edgbaston B15 2WB**

**Tel : 0121 371 6420 Fax : 0121 414 9914**

|  |  |
| --- | --- |
| **INVESTIGATION(S) REQUIRED :**  |  |

|  |  |
| --- | --- |
| **PREVIOUS INVESTIGATION(S) :**  |  |

Please indicate below if you would like a particular Consultant to report upon this test :

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Dr A P Mocroft** | **Dr R Jain** | **Dr C Shirley** | **Dr A Garg** | **No preference** |

**This test is : URGENT / ROUTINE Mobility : WALK / CHAIR / BED**

**PATIENT DETAILS : *(please affix patient label if available)***

**SURNAME : DATE OF BIRTH : MALE/FEMALE**

**FORENAME : HOSPITAL : OP / IP WARD**

**ADDRESS :**

**POST CODE : REFERRING CONSULTANT :**

**TEL NO : HOSPITAL NO :**

**GP NAME & ADDRESS :**

**IS THERE A PARTICULAR QUESTION YOU HOPE THIS INVESTIGATION WILL ANSWER ?**

**CLINICAL DETAILS : (including physical signs, provisional diagnosis, clinic letter)**

**MEDICATION(s) :**

**Anti-coagulants / Pacemaker / Defibrillator ?**

**Date of Request ...................................... Patient’s next Out Patient Appointment ................................**

**Clinician requesting test (PLEASE PRINT NAME CLEARLY) .............................................................................**