Welbeck

Welbeck Heart Health Invasive Procedure Request

Please complete all sections of the form. **By completing this form, you confirm you have the consent required to share this information.**

PATIENT DETAILS

Title:	Forename:	Surname:
MRN:		
Date of birth:		Gender: ☐ Male ☐ Female ☐ Other
Residential address:		Postcode:
Telephone:	Mobile:	Email:

PROCEDURE(S)

- ☐ 20143 Removal of implantable ECG loop recorder
- ☐ K5710 – Ablation of atrioventricular junction
- ☐ K5761 – Ablation of atrial fibrillation by isolation of the pulmonary veins using Farapulse (PFA) (Only AXA, Bupa + Cigna)
- ☐ K5760 – Ablation of atrial fibrillation by isolation of the pulmonary veins including cryoablation (for Vitality patients only)
- ☐ K5760-CAR – Ablation of atrial fibrillation by isolation of the pulmonary veins (including mapping) (CARTO) (for Vitality patients only)
- ☐ K5730 – Ablation of atrial arrhythmia
- ☐ K5730-CAR – Ablation of atrial arrhythmia (including mapping) (CARTO)
- ☐ K5780 – Ablation of accessory pathway or selected modification of AV node
- ☐ K5780-CAR – Ablation of accessory pathway or selected modification of AV node (CARTO)
- ☐ K5720 – Ablation of AV nodal re-entry tachycardia (K5780)
- ☐ K5720-CAR – Ablation of AV nodal re-entry tachycardia (CARTO)
- ☐ K5710-CAR – Ablation of atrio-ventricular junction (including mapping) (CARTO)
- ☐ K5790-CAR – Ablation of left atrial tachycardia (including mapping) (CARTO)
- ☐ K5810-CAR – CARTO - Diagnostic intracardiac electrophysiological study (including characterisation of intracardiac conduction and any testing of anti-arrhythmic drug efficacy by programmed stimulation)
- ☐ K5810 – Diagnostic intracardiac electrophysiological study
- ☐ X5020 – External cardioversion (DCCV)
- ☐ 64302 – Trans-esophageal echocardiography (TOE)
- ☐ K1680 – Transluminal closure of atrial septal defect (ASD) / patent foramen ovale (PFO)
- ☐ K6000 – Single chamber permanent pacemaker insertion
- ☐ K6010 – Dual chamber permanent pacemaker insertion
- ☐ K6015 – Implantation of biventricular pacemaker
- ☐ K6030 – Replacement of generator for intravenous cardiac pacemaker system (without lead change)
- ☐ K6111 – Insertion of combined biventricular pacemaker and cardioverter defibrillator (CRT-D)
- ☐ K6100 – Insertion of single chamber implantable cardioverter defibrillator (ICD)
- ☐ K6050 – Replacement implantable cardioverter defibrillator (ICD), without lead change
- ☐ K6105 – Insertion of dual chamber implantable cardioverter defibrillator (ICD)
- ☐ K6115 – Insertion of an implantable cardioverter defibrillator with subcutaneous leads (subcutaneous ICD)
- ☐ K080 – Removal of pacing system without bypass (including leads)
- ☐ K6120 – Insertion of leadless (wireless) pacemaker
- ☐ K6020 – Resiting of Pacemaker or implantable cardioverter defibrillator (ICD)
- ☐ K6060 – Lead replacement for Pacemaker or implantable cardioverter defibrillator (ICD)

Sedation: ☐ L/A ☐ GA ☐ Regional block ☐ Other:		
Anaesthesist:	Estimated procedure duration:	
Date & time of procedure (if known):	Position on list:	
Equipment required:		
Imaging required in Theatre	☐ Yes	☐ No
COVID –19 Screening (within 7 working days):	☐ Yes	☐ No
Take home medication confirmed and provided:	☐ Yes	☐ No

Please attach the last clinic letter, any relevant test results and any additional documentation to this form & submit to us via one of the following:

T: +44 (0)203 653 2005
E: bookings.invasivecardiology@onewelbeck.com

A: Welbeck Heart Health & Lung Health
1 Welbeck Street, London W1G 0AR

Welbeck

WELBECK HEART HEALTH INVASIVE PROCEDURE REQUEST

Referrer name:	
Originating Physician (if Heart Health partner):	

DRUG & MEDICAL HISTORY (TICK YES IF RELEVANT)

Anticoagulant/Antiplatelet	☐ Yes	☐ No	Rheumatoid arthritis	☐ Yes	☐ No
Aspirin	☐ Yes	☐ No	Cardiac vascular pacemaker	☐ Yes	☐ No
Diabetes – Insulin / Tablet	☐ Yes	☐ No	Respiratory	☐ Yes	☐ No
Allergies (please list in other)	☐ Yes	☐ No	Ability to consent	☐ Yes	☐ No
Infective (E.G. HIV / TB / Hepatitis)	☐ Yes	☐ No	Mobility problems (please specify)	☐ Yes	☐ No
Other (please state):					

EXTRA REQUIRMENTS

Special equipment requirements:	Wheelchair access: ☐ Yes
Interpreter required: ☐ Yes, please confirm language:	
Other:	Dietary requirements:

GP (OR OTHER REFERRER) DETAILS

Gp/referrer name:	Gp/referrer practice:
Gp/referrer contact number:	Gp/referrer email:

PAYMENT DETAILS

TYPE: ☐ Self-funding ☐ Insured ☐ Embassy ☐ Other (please complete below sections as appropriate)		
Insurance company:	Membership no.	Authorisation code:
Embassy:	Letter of guarantee: ☐ Yes (please attach)	

DECLARATION & FORM SUBMISSION

☐ I authorise this patient to undergo the above order.

Name:	Signed:	Date:

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