

**Diagnostic and Consultation Testing Registration Form – HeartScan Ltd**

Before signing this form you should read the HeartScan Diagnostic and Consultation Testing Terms and Conditions. **If you have any questions about them, please ask us.**

Patient's full name: .....

Address: .....  
.....  
.....

Email address: .....

Mobile telephone number: .....

Date of birth: .....

Date and time of Testing appointment: .....

Venue for Testing appointment: The Osborne Clinic, 22 Osborne Avenue, Jesmond, Newcastle upon Tyne NE2 1JQ.

Diagnostic test(s) to be provided: ECG / Echo/ Wireless Patch ECG monitoring [***delete as applicable***]

Clinician referring the Patient for the Testing ("Referring Clinician") (where applicable):  
Name:.....  
Address:.....  
.....

Please note that if you have a Referring Clinician, we will, if you consent, send them the Testing results and you will need to arrange with your Referring Clinician to obtain your results. If you so request we can also send the results direct to you. If you would like us to send your results to you as well as (or instead of) to your Referring Clinician, please ✓ in the box [ ].

Please note - If you do not have a Referring Clinician then we will send your Testing results to you automatically using the method that you request below.

Please specify the method by which you authorise us to deliver your Testing results to you (if applicable): Post / Email [***delete as applicable***]  
Email address (if applicable):.....

Please note that where you specify that you would like your results by email, we will send them in encrypted form and you will need to create an account with our encryption provider. If we send results by post, we will use some form of certified or recorded delivery for which you will need to sign.

Testing Fee:

If an insurer is paying all or part of the Testing Fee, please provide the name and address of your insurer ("Insurer"), your policy number and your pre-authorization number:

Name:.....  
 Address:.....  
 .....  
 Policy Number: .....  
 Pre-authorization number:.....

**Where a Patient is less than 18 years of age**

If you are less than 18 years of age, a person with parental responsibility must sign this form as well as you. Please see the second declaration below.

**Declaration (Patient)**

I acknowledge that:

- (where the Patient has a Referring Clinician) the Referring Clinician has advised that I obtain the Testing referred to above; **or**
- (where the Patient does not have a Referring Clinician) I have requested HeartScan Limited to carry out the Testing referred to above  
**[delete one of these two options, as applicable].**
- I confirm that I have read the HeartScan Diagnostic Testing Terms and Conditions and consent to receive the Testing referred to above on those Diagnostic Testing Terms and Conditions.
- Where applicable, I confirm that I do/do not **[delete as applicable]** consent to the results of the Testing being provided to the Referring Clinician named above. You can withdraw your consent – to do so, please contact us. Please see clause 6.4 of the HeartScan Diagnostic and Consultation Testing Terms and Conditions for further information.
- I understand and confirm that it is my responsibility to arrange to discuss my Testing results with either my Referring Clinician (where applicable) or my GP (if there is no Referring Clinician).

Signed: .....

Date:.....

**Declaration (person with parental responsibility where Patient less than 18 years of age)**

- I confirm that I am a person with parental responsibility for the Patient.
- I confirm that I have read the HeartScan Diagnostic Testing Terms and Conditions.
- I confirm that I accept those Diagnostic Testing Terms and Conditions on the Patient's behalf.
- I confirm that I consent to the Patient receiving the Testing [**only required where the Patient is not competent to provide their own consent – delete if not applicable**].
- I confirm that where the Patient has a Referring Clinician, I do/do not [**delete as applicable**] consent to the results of the Testing being provided to the Referring Clinician [**only required where the Patient is not competent to provide their own consent – delete if not applicable**]. You can withdraw your consent – to do so, please contact us. Please see clause 6.4 of the HeartScan Diagnostic and Consultation Testing Terms and Conditions for further information.

Signed: ..... Date:.....

Name: .....

Address: .....  
.....  
.....

Email: .....

Mobile: .....

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This form relates to the provision of cardiac diagnostic testing services by HeartScan Ltd, company registered in England and Wales under company number 08999669 with its registered office at 28 Mulgrave Terrace, Gateshead, Tyne and Wear, NE8 1PQ. Our privacy notice is on our website <https://heartscan.co.uk/> and we can provide a copy on request.