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| **Was an ECG performed?** | Yes | | No | | **Date of ECG** | DD/MM/YYYY | |  |
| **Time of ECG**  *HH:MM* | | **Was the result abnormal?**  *1 = Yes*  *2 = No* | | **If yes, was it clinically significant?**  *1 = Yes*  *2 = No* | | | **Comments** | |
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