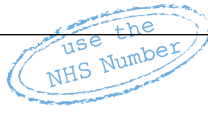


RAPID ACCESS CHEST PAIN CLINIC REFERRAL FORM

Please complete ALL sections on the proforma and fax to the cardiology department:
01895 279 712 – Hillingdon Hospital
01895 828 962 – Harefield Hospital

(Practice Stamp)



Patient details

NHS no.

--	--	--	--	--	--	--	--	--	--	--	--

Patient name:

.....

Address:

.....

Post code:

.....

Tel no.

.....

D.O.B:

____/____/____

Male

Female

Ethnic group:

.....

Hospital number

.....

Referral date

____/____/____

GP details

Referring GP:

.....

GP tel no.

.....

GP address:

.....

GP fax no.

.....

Post code:

.....

Chest pain details

Symptom onset ____ weeks ____ days

Frequency >1/day

1-6/week

<1/week

Symptoms on exertion Yes No

Symptoms at rest Yes No

Heart sounds normal Yes No

Haemoglobin Date .../.../...

Previous cardiac history Yes No

If yes, please refer to a consultant cardiology outpatient clinic, the Rapid Access Clinic is designed for quick access for the assessment of new chest pain

Relevant medical history

Current treatment

Risk factors

Diabetes mellitus Yes No

If yes, treatment Insulin

Oral agents

Diet

If no, fasting glucose (if known) __mmol/l

Date measured _____

Smoker Yes ____/day

No Ex

Lipids (if known) Fasting Random

Date measured _____

Total cholesterol _____ mmol/l

LDL _____ mmol/l

HDL _____ mmol/l

Triglycerides _____ mmol/l

Hypertensive Yes No

Duration ____years ____ months

Current BP ____/____ mmHg

Family history of premature CHD Yes No

(1st degree relative M≤55 yrs, F≤60 yrs)

Likely diagnosis

Angina

Non cardiac pain

Other relevant information _____

Signed by GP

Date: ____/____/____