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)

use the NHS Number

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 address: .....

.....

GP tel no. .....

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:** _____/_____/_____