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| **Rapid Access Chest Pain Referral Form** | | | | |
| **(Chest pain of recent onset of less than 12 weeks)** | | | | |
|  | |  | |  |
| **Date of GP Appointment (DD/MM/YYYY)** | | **Date Fax referral received**  **(DD/MM/YYYY)** | | **Date of RACPC appointment**  **(DD/MM/YYYY)** |
|  | |  | |  |
|  | | | | |
| **NB All fields must be completed or no appointment can be made** | | | | |
|  | | | | |
| **RACPC exclusion criteria**  *If the patient has any of the following* ***RACPC exclusion criteria****, please refer to a* ***general cardiology clinic*** *instead.* | | | | |
| * Chest pain history > 12 weeks * PCI or CABG within last five years * Coronary angiography within  last five years * Stage 4 or 5 Chronic Kidney Disease   (eGFR <30 or on dialysis) | | | * Age under 30 years * Coronary heart disease excluded by other investigation in the last three years * Complex co-morbidities requiring Consultant Cardiologist opinion | |
| *Please read the statements above and sign below to confirm that* ***none of the exclusion criteria apply:*** | | | | |
| *Referring GP signature* | **Sign (print name)** | | | **Date (DD/MM/YYYY)** |

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| **Patient details** | | | | | | | | |
| **Name** |  | | | | | | | |
| **Address** |  | | | | | | | |
|  |  | | | | | | | |
| **Postcode** |  | | | | **Tel no.** | |  | |
| **First language** | |  | | | | | | |
| **Male** |  | **Female** |  | **Interpreter required?** | | Yes | | No |

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| **Referring practice details** | | | | |
| **Referring GP email** | |  | | |
| **Practice address** |  | | | |
|  |  | | | |
| **Postcode** |  | | **Tel. no.** |  |
| **Fax no.** |  | | **Referral date (DD/MM/YYYY)** |  |

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| **Cardiovascular risk profile** | | | | | |
| **Diabetes** | Yes | No | **Hyperlipidaemia** | Yes | No |
| **Current smoker  (or stopped in last 12 months)** | Yes | No | **Hypertension** | Yes | No |
| **Family History CHD  (First generation relative – Father/brother <55yrs Mother/sister <65yrs)** | | | | Yes | No |

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| **Relevant past medical history** |
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| **Examinations and investigations *(These results must be within the last three months)*** | | |
| **Sample** | **Results** | **Date (DD/MM/YYYY)** |
| **HB** |  |  |
| **Platelets** |  |  |
| **Creatinine** |  |  |
| **Urea** |  |  |
| **Total cholesterol** |  |  |
| * **HDL** |  |  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **ECG (If completed please attach)** | Yes | No | **BP** |  | **Heart rate** |  |

|  |  |
| --- | --- |
| **Current medication *(List current prescription)*** | |
|  | |
| Drug sensitivity |  |

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| **QEHB *(Information to be filled in by receiving clerical staff)*** |
|  |