|  |  |
| --- | --- |
| Patient Details:Name:Address:Postcode:Telephone no:Date of Birth:Hospital Unit No:NHS No: | GP Details:Name:Address:Postcode:Telephone No:Practice Code: |

#### Please indicate site preference County/Royal Stoke

**Please note whilst every effort will be made to accommodate preference this cannot be guaranteed**

#### Please circle a yes or no response to every question

#### Exclusion Criteria

#### Has there been a previous diagnosis of coronary disease (angina, MI, PCI or CABG)? Yes / No

#### Has there been a previous diagnosis of significant heart disease including heart failure, Valve disease or cardiomyopathy Yes / No

#### Has the patient undergone assessment or treatment by a cardiologist in the past 5 years Yes / No

#### Presenting symptoms

#### Is the predominant symptom a heavy / tight / constricting discomfort, pain or pressure in the front of the chest, neck, shoulders, jaws or arms? Yes / No

#### Is the symptom precipitated by physical exertion? Yes / No

#### Is the symptom relieved by either rest or GTN in about 5-minutes Yes / No

#### Risk factors for coronary artery disease

#### Age?

#### Gender? Male / Female

#### If female, is the patient post-menopausal? Yes / No

#### Is there any history of smoking ? Yes / No

#### Is there a history of diabetes mellitus? Yes / No

#### Is there a history of hyperlipidaemia? Yes / No

#### Is there a history of hypertension? Yes / No

#### Is there a family history of premature coronary disease? Yes / No

#### Is the patient overweight or obese (BMI >27)? Yes / No

#### Signature: ……………………………………………………. Date: …………………………………

#### Please fax your completed form to the clinic co-ordinator on 08436365239

**If you need to speak clinic co-ordinator please telephone 01782 675936**

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**Rapid Access Chest Pain Service Referral Form – page 2 of 2**

**Date of blood tests:\_\_\_\_\_\_\_\_\_\_\_**

|  |  |
| --- | --- |
| **HB** | **Na** |
| **WBC** | **K** |
| **Platelets** | **Creat** |
| **INR** | **Urea** |
| **TFT** | **eGfr** |
| **Total Cholesterol** | **Random Glucose** |

**Is there any clinical indication of significant valvular heart disease? Y/N**

**Please provide details of any significant comorbidity**

**Please attach recent ECG with referral.**

**Please note if an ECG is unavailable we will contact the patient to arrange to have an ECG. This may not necessarily be at the same time as any clinic appointment**