Single Cardiology Referral Form

**Date:**

**Patient Details:**

Name:

DOB:

NHS No: M/F: Ethnicity:

Address:

Postcode:

Tel Home: Tel Work:

Mobile: Preferred Tel No:

**Referring Clinician:**

Name:

Practice:

Tel:

**Clinical Details (please complete as appropriate)**

Smoking Status:

Alcohol units/week:

BMI: BP:

Betablocker

Aspirin

Statin

ACE/ARB

Nitrate

Digoxin

Anti-coagulation

Diuretic

**Past Medical History:**

MI

Diabetes

CVA/TIA

PVD

AF

**Reason for Referral (tick box) or make clear if requesting advice and guidance only**

RACPC **MUST HAVE** onset of chest pain suspicious of \*angina within the last 3 months, include blood results: HB, creatinine, and cholesterol.

Other Chest pain – possibility of angina, greater than 3 months duration

Suspected heart failure. BNP measurement essential. If <400pg/ml – heart failure very unlikely. If greater than 2000pg/ml – **Urgent referral.** If AMI within last 6 months – **Urgent referral**

Palpitations/rhythm disturbance, including AF

Other – specify below

Brief relevant history and examination findings: (CXR results if available and ECG essential - attach)

\*typical angina symptoms – requires 2 out of 3 of: Constricting discomfort in chest/neck/shoulders/jaw/arms OR precipitated by physical exertion OR Relieved by rest or within 5 minutes.