BIRMINGHAM RAPID ACCESS CHEST PAIN CLINIC
REFERRAL FORM

DATE OF GP APPOINTMENT [ ] DATE RECEIVED [ ] APPOINTMENT DATE [ ]

PATIENT DETAILS

Name: ----------

SEX: Male/Female DOB: ----------

NHS Number: ----------

Address: ----------

Post Code: ----------

Tel No: ----------**(Mandatory)**

Hospital Number: **----------**

1st Language: **----------**

GP DETAILS

GP Name: ----------

Practice Name:----------

Practice Stamp:

Tel: ----------

Fax: ----------

E-mail: ----------

ESSENTIAL CRITERIA FOR REFERRAL *(All answers must be YES)*

1. Central Chest Pain on exertion **YES**/no
2. Duration less than **TWELVE** Weeks **YES**/no

3a. If **MALE**, aged over 30 years **YES**/no

3b. If **FEMALE**, aged over 40 years **YES/**no

CONTRAINDICATIONS FOR FAST TRACK ANGINA CLINICAL *(If YES, refer to Cardiology out patients)*

1. Atypical Chest Pain **NO**/yes
2. Uncontrolled Hypertension **NO**/yes
3. Heart Failure **NO**/yes
4. Arrhythmia **NO**/yes
5. Valvular Heart Disease **NO**/yes
6. Unstable/Crescendo Angina **NO**/yes
7. Suspected Myocardial Infarct **NO**/yes

**** if 6 or 7 contact hospital to consider admission***

If any questions are unanswered or contrary to criteria, the form will be returned and NO APPOINTMENT WILL BE MADE

OTHER HISTORY If available: *Please indicate tests undertaken*

1---------- 2---------- 3----------

Risk Factors Diabetes **YES/NO** Smoker **YES / NEVER / Ex –smoker > 1 year**

Examination and Investigations *(If available in last 3 months)*

1. Pulse ----------/ min [ ]
2. Weight ----------kg [ ]
3. Haemoglobin ----------g/dl [ ]
4. Total cholesterol ---------- mmol/l [ ]
5. ECG attached? **YES/NO** [ ]
6. BP ----------mm/Hg [ ]
7. BMI ----------kg/m [ ]
8. Creatinine ----------mmol/l [ ]

Current Medication

1. ---------- **3. ----------** **5. ----------**

2. ---------- **4. ----------** **6. ----------**

Drug Sensitivity

1. ----------

2. ----------

REFERRAL DESTINATION

Hospital (please tick)		Fast Track Angina Clinic Telephone	Fax
BIRMINGHAM HEARTLANDS HOSPITAL	**( )**	**0121 424 3736**	**0121 424 1072**
CITY	**( )**	**0121 507 5805**	**0121 507 6136**
GOOD HOPE HOSPITAL	**( )**	**0121 424 7476**	**0121 424 7376**
SANDWELL	**( )**	**0121 607 3404**	**0121 607 3058**
SOLIHULL	**( )**	**0121 424 5000**	**0121 424 5001**
UNIVERSITY HOSPITAL	**( )**	**0121 627 2492**	**0121 460 5849**