**Referral to the Cardiology Clinic**

**(Please tick)**

**ISCHAEMIC HEART DISEASE**  **ARRHYTHMIA**  **OTHER**

*If heart failure suspected please use the designated SFT Heart Failure referral template*

**Patient Details:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Hospital no. |  | NHS no. |  | | |
| Surname |  | Forenames |  | | |
| Previous surname |  | Title |  | Gender |  |
| Date of birth |  | Home tel. no. |  | | |
| Address |  | Mobile no. |  | | |
| Work tel. no. |  | | |

**Referrer Details:**

|  |  |  |  |
| --- | --- | --- | --- |
| Name |  | Date of Referral |  |
| Base |  | Practice Code/ID |  |
| Address |  | Telephone |  |

**Communication and Accessibility needs:**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Interpreter required? | Yes |  | No |  | Wheelchair access required? | Yes |  | No |  |
| Language: |  | | | | Learning Disability: |  | | | |
| Hearing: |  | | | | Other disability needing consideration: |  | | | |
| Vision: |  | | | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Military Service Person |  | Military Veteran |  | Member of Military Family |

**Current medication (please list):**

|  |  |
| --- | --- |
| Acutes |  |
| Repeats |  |
| **Allergies:** | |

**Investigations:**

**Please ensure the following investigations have been done within the past month and tick to confirm:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| UECreat |  | Random glucose |  | FBC |  |
| Random cholesterol |  | LFT |  | TFT |  |
| **ECG:** |  |  |  |  |  |

**Please attach an up-to-date ECG, which is essential to enable the team to provide a quality assessment of the referral. (This can be done by attaching a screenshot).**

**If there are exceptional circumstances which mean an ECG cannot be attached, please outline below.**

|  |
| --- |
|  |

**Blood Results** (Last 12m):

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **FBC** |  |  | | |
| **UE** |  |  | | |
| **LFT** |  |  | | |
| **CRP** |  |  | **ESR** |  |
| **TFTs** |  |  | **INR** |  |
| **Bone** |  |  | | |
| **Iron** |  |  | | |
| **Vitamins** |  |  | | |
| **Lipids** |  |  | | |
| **Random Glucose** | |  | **Fasting Chol.** |  |
| **Fasting Glucose** | |  | **HbA1c** |  |
| **BNP** | |  | **NT-proBNP** |  |

**History of presenting complaint:**

|  |
| --- |
|  |

**Medical Problems:**

|  |
| --- |
|  |

**Please send via eRS** [**shc-tr.salisburyreferralcentre@nhs.net**](mailto:shc-tr.salisburyreferralcentre@nhs.net)

**For suspected coronary artery disease referrals please see guidance attached.**

