**RAPID ACCESS CARDIAC CHEST PAIN REFERRAL FORM**

This form is for the specialist assessment of patients with **suspected angina**.

**Referral Criteria:**

* Exertional chest pain suggestive of new onset angina
* Women aged <40 yrs & men <30 yrs to be referred in exceptional circumstances only
* Patients with established IHD should be referred to general cardiology
* If symptoms are thought to be secondary to significant arrhythmia e.g. AF consider referral to Rapid AF clinic
* **Patients with suspected Acute MI / Unstable Angina new LBBB treat as per: Initial management of suspected acute coronary syndromes in ED/acute medicine**

|  |  |
| --- | --- |
| **Patient Details** | **Referrer Details** |
| Patient Name |  | Name Designation |  |
| Hospital Number |  | Department/Address |  |
| Date of Birth |  | Contact Number |  |
| Telephone Number |  | Date of Referral |  |

**Additional Information:**

|  |  |  |
| --- | --- | --- |
| **Please complete all fields** | YES | NO |
| Is the chest pain / discomfort: |  |  |
| Constricting in the chest, neck, shoulders, jaw or arms |[ ] [ ]
| Precipitated by physical exertion |[ ] [ ]
| Relieved by rest or GTN in approx. 5 minutes |[ ] [ ]
| Abnormal ECG (T wave, ST changes) |[ ] [ ]

|  |  |  |
| --- | --- | --- |
| **Risk factors** | YES | NO |
| Family history IHD 1ST degree relative <60yrs |[ ] [ ]
| Diabetes |[ ] [ ]
| Smoking |[ ] [ ]
| Hypertension |[ ] [ ]
| hypercholesterolemia |[ ] [ ]

**Please email completed referral to:** **sft.racpreferral@nhs.net**