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**Referral to the Cardiology Clinic**

**CHEST PAIN ARRHYTHMIA HEART FAILURE OTHER (please circle)**

**Patient Details:**

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

**Referral Details:**

|  |  |  |  |
| --- | --- | --- | --- |
| Referring clinician |  | GP Practice/Department |  |
| Date of referral |  |  |  |

**Communication needs**

|  |
| --- |
|  |

**Current medication (please list):**

|  |
| --- |
|  |

**Investigations:**

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

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| UECreat |  | Random glucose |  | FBC |  |
| Random cholesterol  NTproBNP  (Heart failure patients only) |  | LFT |  | TFT |  |
|  |  | | | | |

**History of presenting complaint:**

|  |
| --- |
|  |

**Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please email to:-** [**shc-tr.salisburyreferralcentre@nhs.net**](mailto:shc-tr.salisburyreferralcentre@nhs.net)

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

