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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 |       |  |  |
| AddressPost 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**

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

