Concern regarding cardiac chest pain ?

No

Alternative pathway suggested

**RAPID ACCESS CHEST PAIN CLINIC**

Please **send via eRS**  to Cardiology RACP (Rapid Access Chest Pain)

Yes

Any unstable features:

* Rest pain?
* Rapidly accelerating symptoms?
* Concern regarding acute coronary syndrome (ACS)?

Consider Hospital admission

Yes

No

Typical angina?

(3 out of 3)

* Constricting discomfort in chest/neck/shoulder/jaw
* Precipitated by physical exertion
* Relieved with rest or GTN

**OR**

Atypical angina?

(2 out of 3)

* Constricting discomfort in chest/neck/shoulder/jaw
* Precipitated by physical exertion
* Relieved with rest or GTN

**OR**

Non-anginal chest pain with Q waves/ST changes?

(0 or 1 out of 3)

* Constricting discomfort in chest/neck/shoulder/jaw
* Precipitated by physical exertion
* Relieved with rest or GTN

**Known Coronary Artery Disease (CAD)?**

* Previous myocardial infarction (MI)?
* Previous Percutaneous Coronary Intervention (PCI)/Stenting?
* Previous Coronary Artery Bypass Graft (CABG)?
* Previous CAD on Computed Tomography Coronary Angiography (CTCA)?
* Previous CAD on Invasive Coronary Angiogram (ICA)?

No

Yes

GO TO PAGE 4

Please complete details below

|  |  |
| --- | --- |
| **Patient Details** | **Referring GP** |
|  |  |
| **Forename** | **Name** |
| **Surname** |  |
|  |  |
| **Gender** |  |
| **Date of birth**  |  |
| **Telephone number** |  |
|  |  |
| **Address line 1** | **Date** |
| **Address line 2** |  |
| **Address line 3** |  |
| **Postcode** |  |

|  |
| --- |
| **Current medications (or enclose with referral)?** |
|  |
| **Significant past medical history (or enclose with referral)** |
|  |
| **Current problem/question being asked of the RACPC service?** |
|  |
| **Please indicate presence of cardiac risk factor by placing an “X” in the box below as appropriate** |
| **Hypertension** | **Smoker/Ex-smoker** | **Dyslipidaemia** | **Diabetes Mellitus** | **Family History**  | **BMI >25 kg/m2** |
|  |  |  |  |  |  |

**No known Coronary Artery Disease (CAD)**

Please complete details below

|  |  |
| --- | --- |
| **Patient Details** | **Referring GP** |
|  |  |
| **Forename** | **Name** |
| **Surname** |  |
|  |  |
| **Gender** |  |
| **Date of birth**  |  |
| **Telephone number** |  |
|  |  |
| **Address line 1** | **Date** |
| **Address line 2** |  |
| **Address line 3** |  |
| **Postcode** |  |

|  |
| --- |
| We are now requesting Computed Tomography Coronary Angiography (CTCA) imaging for patients without CAD prior to them being seen in the RACPC. This is based on your clinical judgement. Please indicate that having reviewed the patient, the information that you have provided is accurate and that you give approval for us to book a guideline directed test that uses ionising radiation on your behalf. We will follow up and action the results of the diagnostics.**Please indicate consent to this by placing an “X” in the box below.** **GP NAME:** |
| **PLEASE INDICATE YES BY PLACING AN “X” IN THE BOX****PLEASE NOTE REFERRALS WITH INCOMPLETE ANSWERS TO THIS BOX WILL BE RETURNED** | **Yes** | **No** |
| Typical angina? (3 of the following)* Constricting discomfort in chest/neck/shoulder/jaw
* Precipitated by physical exertion
* Relieved with rest or GTN
 |  |  |
| Atypical angina? (2 out of 3)* Constricting discomfort in chest/neck/shoulder/jaw
* Precipitated by physical exertion
* Relieved with rest or GTN
 |  |  |
| Non-anginal chest pain with Q waves/ST changes? (1 or none of the following)* Constricting discomfort in chest/neck/shoulder/jaw
* Precipitated by physical exertion
* Relieved with rest or GTN
 |  |  |
| Pregnant? |  |  |
| Iodine allergy? |  |  |
| Any significant condition that may limit beta blocker use?* Hypotension (BP <90/60 mmHg)
* Poorly controlled asthma
* Severe peripheral vascular disease
* Uncontrolled heart failure
* 2nd/3rd degree heart block
 |  |  |
| Known >moderate aortic stenosis or murmur not been formally quantified? |  |  |
| eGFR <30 ml/m2  |  |  |
| * If their heart rate in clinic is **>65 bpm** and on rate controlling medication then please **increase dose (as an anti-anginal)**
* If their heart rate in clinic is **>65 bpm** and not on rate controlling medication then please prescribe **Bisoprolol 2.5 mg (as an anti-anginal agent)**
* If there is concern around beta blocker use then please prescribe **Ivabradine 5 mg bd (as an anti-anginal agent)**
 |  |  |
| **Have you prescribed rate limiting medications as above?** |  |  |

|  |
| --- |
| **Current medications (or enclose with referral)?** |
|  |
| **Significant past medical history (or enclose with referral)** |
|  |
| **Current problem/question being asked of the RACPC service?** |
|  |
| **Please indicate presence of cardiac risk factor by placing an “X” in the box below as appropriate** |
| **Hypertension** | **Smoker/Ex-smoker** | **Dyslipidaemia** | **Diabetes Mellitus** | **Family History**  | **BMI >25 kg/m2** |
|  |  |  |  |  |  |

If you feel for any reason that a CTCA (CT Coronary Angiogram) test would be inappropriate for your patient please indicate this by giving a reason in the box below. This does not affect their referral to the RACPC.

|  |
| --- |
|  |

**Thank you for the referral**