

Date of referral	
<b>PATIENT DETAILS</b>	
ID number	
Title	
Name	
Telephone	
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female
Date of birth	
Address	
Post code	

Referring clinician	
Commissioning Org	
<b>GP DETAILS</b>	
GP name and Signature	
Telephone	
Fax Number	
Address	
GP Email	
<b>SPECIAL REQUIREMENTS</b>	
<input type="checkbox"/> Interpreter required – which language?	
<input type="checkbox"/> Transport required	

<b>REASON FOR REFERRAL (Please ensure to select at least ONE)</b>
<p><u>Patients with suspected heart failure</u></p> <p><input type="checkbox"/> 1. Suspected CCF based on clinical findings (dyspnoea or peripheral oedema)</p> <p><input type="checkbox"/> 2. Suspected CCF based on abnormal ECG or abnormal chest X ray</p> <p><input type="checkbox"/> 3. Suspected CCF based on raised BNP or NT pro-BNP</p> <p><u>Patients with heart murmur</u></p> <p><input type="checkbox"/> 4. Heart murmur with cardiac symptoms</p> <p><input type="checkbox"/> 5. Asymptomatic heart murmur with abnormal ECG or abnormal chest X ray</p> <p><u>Other</u></p> <p><input type="checkbox"/> 6. Suspected cardiomyopathy or left ventricular hypertrophy based on clinical findings or abnormal ECG or abnormal chest X ray</p>

If this echo service wasn't available, would you have referred this patient to the Acute Trust? <input type="checkbox"/> Yes <input type="checkbox"/> No
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<b>RELEVANT PAST MEDICAL HISTORY</b>		
<input type="checkbox"/> MI	<input type="checkbox"/> Atrial Fibrillation	<input type="checkbox"/> Thyroid disease
<input type="checkbox"/> Angina	<input type="checkbox"/> Cardiomyopathy	<input type="checkbox"/> Alcohol / Drug abuse
<input type="checkbox"/> Valve disease	<input type="checkbox"/> Hypertension	<input type="checkbox"/> COPD
<input type="checkbox"/> Cardiac surgery	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Other

<b>MEDICATION (Drug and Dose)</b>

INVESTIGATIONS (where relevant)	Date	Please enter values:
12 lead ECG		<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal (Please attach)
CXR		<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
BMI		
BP		
BNP		<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal