



BCH
Bass Coast Health

Rapid Access Cardiology Referral

Surname U.R. No.
 First Name Gender
 Date of Birth / / Age
 Doctor Ward.....
 Address

PLACE LABEL HERE

Referral Date: ____ / ____ / ____

SECTION 1

Referral to:

BCH Cardiology Public Clinic

Cardiology Investigations ONLY –

Address: Access Department
PO Box 120, Wonthaggi VIC 3995

Phone: 5671 3175 Fax: 9102 5307

Email: Access@basscoasthealth.org.au

Referring Doctor (stamp):

Name:

Provider Number:

Address:

Phone:

Fax:

Signature:

Period of referral:

3 months 12 months Indefinite

SECTION 2

CARDIOLOGY REFERRAL CRITERIA:

- Recent chest pain suggestive of angina
- New onset or worsening heart failure (HF)
- New onset atrial fibrillation
- New onset or difficult to control arrhythmia
- Other:

REFERRAL URGENCY

- Urgent – within 14 days
New onset heart failure
New onset/crescendo ischaemic type chest pain
- Routine – within 30 days
All other in- scope criteria (see reverse)

HISTORY OF PRESENTING PROBLEM

Investigations

Please attach any relevant cardiac Investigations and relevant discharge summaries
Please refer To Rapid Access Clinic model protocol on reverse side

Medications

Attach Summary Medication List

See reverse for recommended medications to commence as per referral indication

SECTION 3

Referral for Investigations Required

- Transthoracic (TTE) - HF, Murmurs, arrhythmia, syncope
- Exercise Stress Echocardiography – Chest pain

Send Copy of Results To

Consent to referral and Sharing of Information with cardiac service Yes No

Please email this referral to Bass Coast Health's Access Department: Access@basscoasthealth.org.au



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Bass Coast Health: Rapid Access Cardiology Clinic

In scope	<ul style="list-style-type: none"> • New onset chest pain suggestive of angina • Previously stable ischaemic heart disease with recent deterioration of symptoms • New onset or worsening Heart Failure • New onset or difficult to control Atrial Fibrillation and arrhythmias • Other: Upon discussion with nurse coordinator and cardiology team for consideration
Out of scope	<ul style="list-style-type: none"> • Cardiac conditions requiring urgent admission <ul style="list-style-type: none"> - Troponin positive chest pain - Cardiac Syncope - Acute pulmonary oedema • Likely non-cardiac condition (ie multi-factorial falls in the elderly) • Patients that are under the care of a cardiologist
Referral Source	<ul style="list-style-type: none"> • Internal and External referrals welcomed
Clinic Model	<ul style="list-style-type: none"> • Rapid Access model: 1-2 appointments with Cardiologist and discharge to GP care
Clinic contact details	<ul style="list-style-type: none"> • Please contact the Rapid Access Cardiology clinic nurse co-ordinator with any questions or to flag urgent referrals on 0438 806 478

Rapid access clinic model protocol – please refer patients for the following investigations prior to clinic attendance or attach results

Reason for referral	Medications to be initiated (as appropriate)	Echocardiography	Blood tests to be ordered (all)	ECG	RChest radiograph – CXR
<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Aspirin <input type="checkbox"/> Statin <input type="checkbox"/> GTN spray	<input type="checkbox"/> Stress echo	<input type="checkbox"/> FBC <input type="checkbox"/> U & E <input type="checkbox"/> Magnesium <input type="checkbox"/> Thyroid function <input type="checkbox"/> Fasting glucose <input type="checkbox"/> HBA1C <input type="checkbox"/> Fasting full lipid profile (cholesterol, LDL, TG) <input type="checkbox"/> Troponin <input type="checkbox"/> Coagulation profile	<input type="checkbox"/> Please attach results	<input type="checkbox"/> Please Attach results or refer
<input type="checkbox"/> Arrhythmia: <input type="checkbox"/> AtrialL <input type="checkbox"/> Fibrillation <input type="checkbox"/> Atrial Flutter <input type="checkbox"/> Palpitations	<input type="checkbox"/> Anticoagulation (as per CHA ₂ DS ₂ VAS _c score) <input type="checkbox"/> Beta-blocker (if not asthmatic)	<input type="checkbox"/> Transthoracic echo	<input type="checkbox"/> 24 hr ECG Holter monitor	Patients referred for arrhythmia management:	
<input type="checkbox"/> Heart Failure	<input type="checkbox"/> Frusemide	<input type="checkbox"/> Transthoracic echo			

Office Use Only

Received Date: ____ / ____ / ____ Triaged by: _____
 Accepted Rejected Need further information Clinic Required: _____
 Clinic appointment booked: Date ____ / ____ / ____ Time: _____
 Patient notified by phone/mail: Yes No Date: ____ / ____ / ____
 Notified/processed by: _____

Please note that the absence of required information may lead to delays in processing the referral and subsequent appointment allocation.

MR/310 RAPID ACCESS CARDIOLOGY REFERRAL