Rapid Access Cardiology Referral

Surname ..... U.R. No. .....

First Name ..... Gender .....

Date of Birth ..../..../.... Age .....

Doctor ..... Ward .....

Address .....

PATIENT LABEL

PLACE LABEL HERE

Referral Date: ____ /____ /_____ Sex at birth: _____ Gender: _____

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	**Send Copy of Results To**
☐ Transthoracic (TTE) - HF, Murmurs, arrhythmia, syncope ☐ Exercise Stress Echocardiography – Chest pain	

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

RAPID ACCESS CARDIOLOGY REFERRAL

MR/310

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

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PATIENT LABEL

PLACE LABEL HERE

Bass Coast Health: Rapid Access Cardiology Clinic

In scope	• 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	• Cardiac conditions requiring urgent admission - 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	• Internal and External referrals welcomed
Clinic Model	• Rapid Access model: 1-2 appointments with Cardiologist and discharge to GP care
Clinic contact details	• 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**
☐ **Chest Pain**	☐ Aspirin ☐ Statin ☐ GTN spray	☐ Stress echo	☐ FBC ☐ U & E ☐ Magnesium ☐ Thyroid function ☐ Fasting glucose ☐ HBA1C ☐ Fasting full lipid profile (cholesterol, LDL, TG) ☐ Troponin ☐ Coagulation profile	☐ Please attach results **Patients referred for arrhythmia management:** ☐ 24 hr ECG Holter monitor	☐ Please Attach results or refer
Arrhythmia: ☐ AtriaL Fibrillation ☐ Atrial Flutter ☐ Palpitations	☐ Anticoagulation (as per $CHA_2DS_2VAS_c$ score) ☐ Beta-blocker (if not asthmatic)	☐ Transthoracic echo			
☐ **Heart Failure**	☐ Frusemide	☐ 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: _____

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