

**RAPID ACCESS CHEST PAIN ASSESSMENT CLINIC  
(RACPC) PROFORMA (2 WEEK)**

**This form is only for patients with new onset chest pain suspected to be cardiac in origin. Please complete ALL fields & send via e-referrals with a copy of the patient profile to include drug history and a resting 12 lead ECG from this current presentation of chest pain. If your patient does not have chest pain or has chest pain which is under one of the following headings, please see page (2) for guidance:**

1. Evidence of acute myocardial infarction or unstable angina
2. Known coronary artery chronic total occlusion (CTO).
3. Currently being investigated by a Cardiologist or by the RACPC.
4. Newly revascularized in the last 2 years.
5. Previously investigated by a Cardiologist in the past 12 months and had documented CAD for medical management.
6. Previously investigated by a Cardiologist in the past 5 years and had normal results.
7. Symptoms of heart failure, valve disease or arrhythmia.
8. Non cardiac chest pain (Pain unrelated to activity; Pain brought on through inspiration; pain associated with dizziness, palpitations, tingling or difficulty swallowing. Cardiac chest pain is not described as a sharp localised pain).
9. Significant co-morbidities or cognitive impairment that makes clinical assessment / investigation inappropriate in the RACPC

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| **PATIENT DETAILS:** | | | | | | | | | **GP DETAILS:** | | | | | | | | | | |
| Surname:  First name:  D.O.B.  NHS Number:  Address:    Postcode:  Tel No:  Mobile No: | | | | | | | | | Name:  GMC No:  Practice Code:  Address:    Tel No:  Email:  Date of referral:  Referring Clinician: | | | | | | | | | | |
| Does the patient require an Interpreter? | | | | □ | | | | | Preferred language: | | |  | | | | | | | |
| **CHEST PAIN TYPE** | | | | | | | | | | | | | | | **(Please select appropriate box)** | | | | |
| **Chest pain history please delete appropriately:**   1. Chest pain of characteristic quality, described as any of the following: Discomfort; tightness; ache; pressure; band; squeeze; heaviness across the chest, neck, shoulders, arm or jaw. | | | | | | | | | | | | | | | | | | | □ |
| 1. Precipitated by physical exertion & / or emotional stress & / or weather. | | | | | | | | | | | | | | | | | | | □ |
| 1. Chest pain relieved by rest within about 5 minutes. | | | | | | | | | | | | | | | | | | | □ |
| 1. Chest pain relieved by GTN spray in about 5 – 10 minutes. | | | | | | | | | | | | | | | | | | | □ |
| **Please describe symptoms:** | | | | | | | | | | | | | | | | | | | |
| **CLINICAL EXAMINATION (please ensure information is up to date from this presentation)** | | | | | | | | | | | | | | | **(Please complete)** | | | | |
| Resting heart rate: |  | | | | Blood Pressure: | | |  | | | Heart sounds normal? \* | | | | | | Yes □ No □ | | |
| **CARDIAC RISK FACTORS** | | | | | | | | | | | | | | | **(Please select appropriate box)** | | | | |
| Diabetes: □ | | Hypertension: □ | | | | Current Smoker: □ | | | | Ex-Smoker <10yrs: □ | | | | | | Hyperlipidaemia: □ | | | |
| Family history (1st degree relative with CVD & age of onset in males <55, females <65): □ | | | | | | | | | | | | | Familial hyperlipidaemia: □ | | | | | | |
| **PAST MEDICAL HISTORY** | | | | | | | | | | | | | | | **(Please select appropriate box))** | | | | |
| Other known CHD | | | □ | | | | Previous **CT** Coronary angiogram | | | | □ | | | Asthma | | | | □ | |
| Previous MI: | | | □ Date: | | | | Previous MPS | | | | □ | | | PVD | | | | □ | |
| Previous PCI: | | | □ Date | | | | Atrial Fibrillation | | | | □ | | | CVE/TIA | | | | □ | |
| Previous CABG: | | | □ Date | | | | BMI: | | | |  | | |  | | | |  | |
| **RELEVANT INVESTIGATIONS** | | | | | | | | | | | | | | | **(Please select appropriate box)** | | | | |
| \*New significant murmur present, please arrange an echocardiogram **PRIOR** to RACPC referral to exclude significant aortic stenosis. | | | | | | | | | | | | | | | | | | | □ |
| \*If known aortic stenosis or less significant new murmur and has not had an echo within the last 2 years, please arrange an up-to-date echocardiogram in addition to this RACPC referral. Please attach report if available. | | | | | | | | | | | | | | | | | | | □ |
| Please ensure a **12 lead ECG** from this presentation of chest pain and a **Patient Profile** is included with this referral. The 12 lead ECG must have been reviewed and signed off by an appropriate clinician prior to referral to ensure no acute changes. | | | | | | | | | | | | | | | | | | | □ |
| Please ensure U&Es, FBC, LFTs, TFTs, Lipid profile and HbAIC has been performed with in the last 6 weeks. | | | | | | | | | | | | | | | | | | | □ |
| **Please consider commencing Aspirin and Statin therapy for Secondary prevention in high-risk patients awaiting assessment. In addition, please consider commencing and/or optimising Beta Blocker and ACEi therapy.** | | | | | | | | | | | | | | | | | | | |

**Guidance and Exclusion Criteria**

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|  | **Clinical Findings** | **Advice** |
| **1,** | AMI (including Troponin +ve chest pain) or UA | Arrange for admission via ED. |
| **2.** | Patients with known coronary artery chronic total occlusion (CTO) | Refer for a routine OP general Cardiology clinic. |
| **3.** | Patients who are currently being investigated by a cardiologist or by the RACPC unless under category (1). | Please discuss with the relevant Cardiologist. |
| **4.** | Patients revascularised within the last 2 years | Refer to cardiology outpatients under the care of the consultant cardiologist who performed the revascularisation. If performed out of county, refer to the OP general Cardiology Clinic under the care of an interventionist. |
|  | Patients investigated by a Cardiologist and had documented CAD for medical management in the past 12 months (unless under category (1) | Refer to Cardiology advice and guidance. |
|  | Patients investigated by a Cardiologist in the past 5 years and had normal results (unless under category (1) | Refer to Cardiology advice and guidance. |
| **7.** | Suspected valvular heart disease | Arrange transthoracic echocardiogram and if necessary, refer to OP general Cardiology clinic. Consider admission via ED / acute medical take if clinically indicated. |
| **8.** | Untreated Atrial Fibrillation (or other non-life threatening arrhythmia) | See RMS Atrial Fibrillation guidance. Consider admission via ED or acute medical take if clinically indicated. |
| **9.** | Symptoms due to cardiac failure. | Referral to rapid access heart function clinic may be appropriate as per RAHFC referral criteria. Consider admission via ED or acute medical take if clinically indicated. |
| **10.** | Chest pain which is clearly not due to angina / AMI.  e.g. musculo-skeletal chest pain, trauma, PE, chest infection, etc… | Treat underlying cause. Consider referral to relevant medical / surgical team if clinically indicated. |
| **11.** | Significant co-morbidities (malignancy, significant pulmonary, renal or neurological disease) or cognitive impairment that makes clinical assessment / investigation inappropriate in the RACPC | Refer to Cardiology advice and guidance. |