PROVIDENCE HEALTH CARE   HEART CENTRE

Place Patient Form Label Here

ST. PAUL'S HOSPITAL HEART CENTRE CHEST PAIN CLINIC REFERRAL

Cardiology Referral

St. Paul's Hospital Chest Pain Clinic
Address: Suite 200 – 1033 Davie Street, Vancouver, BC V6E 1M7
Phone: 604-269-0655 **Fax:** 604-689-4219 **Email:** chestpainclinic@providencehealth.bc.ca

Date of Referral: ______________________________

Referred for: ☐ **Cardiac testing and Cardiology consultation**
☐ **Cardiac testing and Cardiology consultation ONLY if test results abnormal**

PATIENT INFORMATION

Name: ____

PHN: ______________________ DOB: (dd/mmm/yyyy) ______________________

Telephone (Home): ____________________ (Cell): ________________________

Gender: ☐ Male ☐ Female ☐ Other: ________

KNOWN CAD:

☐ No ☐ Yes - **Previous Revascularization**
☐ PCI ☐ CABG

CARDIAC RISK FACTORS

☐ Hypertension ☐ Currently smokes
☐ Diabetes ☐ Family history of early atherosclerosis
☐ Dyslipidemia ☐ Other: ____________________

TYPICAL PAIN

☐ Retrosternal chest discomfort
☐ Provoked by exertion/stress
☐ Relieved with rest/nitroglycerin
☐ Other: ____________________________

SEVERITY OF SYMPTOMS

☐ Mild ☐ Moderate ☐ Severe

OTHER KNOWN CARDIAC ISSUES:

____

ADDITIONAL COMMENTS:

____

VITAL SIGNS: **BP:** ________ / _________ **Heart Rate:** ________ bpm (date of vitals: ______________)

ECG: (describe or provide if available) (date of ECG: ______________)

____

REFERRING PHYSICIAN

______________________ ______________________ ____________
Signature Printed name MSP #

Fax or email this referral to the SPH Chest Pain Clinic

Fax: 604-689-4219 Email: chestpainclinic@providencehealth.bc.ca

Patients will be contacted directly by the clinic.

For internal use only

Modality: ☐ ETT ☐ P-MIBI ☐ CCTA ☐ Stress Echo ☐ None

Urgency: ☐ within one week ☐ 1 to 3 weeks ☐ 4 to 6 weeks

Your doctor wants you to go to the

St. Paul's Hospital Chest Pain Clinic

Why do you have to go?

A heart doctor (Cardiologist) at the Chest Pain Clinic will help you find the reason for your chest pain.

What do you need to bring?

Please bring all your medications.
Please wear flat shoes and comfortable clothes.

What will happen at the clinic?

You will do an exercise test, a CAT scan, or a nuclear test (MIBI) before the Clinic visit. At the Clinic, you will talk with a heart doctor. The heart doctor will listen to your heart and explain the problem or order more tests. Your family doctor will get information about your Clinic visit.

Who will call me to set it up?

Someone from the Clinic will call you. If you do not get a call after 2 days, please call the Clinic at the phone number below.

If you do not feel well, please see your family doctor or go to the Emergency Room.

Your stress test, CAT, or MIBI will be at St. Paul's Hospital

Your Clinic visit will be at:

Providence Heart Davie Clinic
200 – 1033 Davie Street
Vancouver, BC
604-296-0655
ChestPainClinic@providencehealth.bc.ca

X 0

BRITISH COLUMBIA | Ministry of Health

STANDARD OUT-PATIENT LABORATORY REQUISITION

ORDERING PRACTITIONER: ADDRESS, PHONE, MSP PRACTITIONER NUMBER

66259 Annie Chou
on behalf of Chest Pain Clinic
200 - 1033 Davie Street
Vancouver, BC
V6E 1M7

Yellow highlighted fields must be completed.

For tests indicated with a blue tick box, consult provincial guidelines and protocols (www.BCGuidelines.ca) https://www2.gov.bc.ca/gov/content/health/practitioner-professional-resources/bc-guidelines

Bill to → [X] MSP [ ] ICBC [ ] WorkSafeBC [ ] PATIENT [ ] OTHER:

PERSONAL HEALTH NUMBER | ICBC/WorkSafeBC NUMBER | LOCUM FOR PRACTITIONER AND MSP PRACTITIONER NUMBER:

LAST NAME OF PATIENT | FIRST NAME OF PATIENT | If this is a STAT order please provide contact telephone number:

DOB YYYY MM DD | SEX [ ] M [ ] F | Pregnant? [ ] YES [ ] NO [X] Fasting? 8-10 h pc | Copy to PRACTITIONER/MSP Practitioner Number:

PRIMARY CONTACT NUMBER OF PATIENT H | SECONDARY CONTACT NUMBER OF PATIENT W | OTHER CONTACT NUMBER OF PATIENT | Copy to PRACTITIONER/MSP Practitioner Number: Family Physician

ADDRESS OF PATIENT | CITY/TOWN | PROVINCE BC | POSTAL CODE

DIAGNOSIS: Chest Pain | CURRENT MEDICATIONS/DATE AND TIME OF LAST DOSE

HEMATOLOGY

- [X] Hematology profile
- [ ] INR
- [ ] Ferritin (query iron deficiency)

On Anticoagulant? [ ] Yes [ ] No
Specify:

HFE - Hemochromatosis (check ONE box only)
- Confirm diagnosis (ferritin first, ± TS, ± DNA testing)
- Sibling/parent is C282Y/C282Y homozygote (DNA testing)

URINE TESTS

- Macroscopic → microscopic if dipstick positive
- Macroscopic → urine culture if pyuria or nitrite present
- Macroscopic (dipstick) Microscopic *

* Clinical information for microscopic required:

CHEMISTRY

- [X] Glucose – fasting (see reverse for patient instructions)
- [ ] Glucose – random
- [ ] GTT – gestational diabetes screen (50 g load, 1 hour post-load)
- [ ] GTT – gestational diabetes confirmation (75 g load, fasting, 1 hour & 2 hour test)
- [ ] GTT – non-gestational diabetes
- [X] Hemoglobin A1c
- [ ] Albumin/creatinine ratio (ACR) - Urine

MICROBIOLOGY – LABEL ALL SPECIMENS WITH PATIENT'S FIRST & LAST NAME, DOB, PHN & SITE

ROUTINE CULTURE

On Antibiotics? [ ] Yes [ ] No Specify:

- [ ] Throat [ ] Sputum [ ] Blood [ ] Urine
- [ ] Superficial Wound, Site:
- [ ] Deep Wound, Site:
- [ ] Other:

VAGINITIS
- [ ] Initial (smear for BV & yeast only)
- [ ] Chronic/recurrent (smear, culture, trichomonas)
- [ ] Trichomonas testing

GROUP B STREP SCREEN (Pregnancy only)
- [ ] Vagino-anorectal swab [ ] Penicillin allergy

CHLAMYDIA (CT) & GONORRHEA (GC) by NAAT
Source/site: [ ] Urethra [ ] Cervix [ ] Urine [ ] Vagina [ ] Throat [ ] Rectum
Other

GONORRHEA (GC) CULTURE
Source/site: [ ] Cervix [ ] Urethra [ ] Throat [ ] Rectum
Other

STOOL SPECIMENS
History of bloody stools? Yes
- *C.difficile* testing
- Stool culture
- Stool ova & parasite exam
- Stool ova & parasite (high risk, submit 2 samples)

DERMATOPHYTES
- [ ] Dermatophyte culture [ ] KOH prep (direct exam)

Specimen: [ ] Skin [ ] Nail [ ] Hair
Site:

MYCOLOGY
- [ ] Yeast [ ] Fungus Site:

HEPATITIS SEROLOGY

Acute viral hepatitis undefined etiology
Hepatitis A (anti-HAV IgM)
Hepatitis B (HBsAg ± anti-HBc)
Hepatitis C (anti-HCV)

Chronic viral hepatitis undefined etiology
Hepatitis B (HBsAg; anti-HBc; anti-HBs)
Hepatitis C (anti-HCV)

Investigation of hepatitis immune status
- Hepatitis A (anti-HAV, total)
- Hepatitis B (anti-HBs)

Hepatitis marker(s)
- HBsAg

(For other hepatitis markers, please order specific test(s) below)

- [ ] **HIV Serology** (patient has the legal right to choose not to have their name and address reported to public health = non-nominal reporting)
  - [ ] Non-nominal reporting

LIPIDS

✓ one box only

Note: Fasting is not required for any of the panels but clinician may specifically instruct patient to fast for 10 hours in select circumstances [e.g. history of triglycerides > 4.5 mmol/L], independent of laboratory requirements.

- [X] Full Lipid Profile - Total, HDL, non-HDL, LDL cholesterol, & triglycerides (Baseline or Follow-up of complex dyslipidemia)
- Follow-up Lipid Profile - Total, HDL & non-HDL cholesterol only
- Apo B (not available with lipid profiles unless diagnosis of complex dyslipidemia is indicated)

THYROID FUNCTION

For other thyroid investigations, please order specific tests below and provide diagnosis.

- Monitor thyroid replacement therapy (TSH Only)
- [X] Suspected Hypothyroidism (TSH first, fT4 if indicated)
- Suspected Hyperthyroidism (TSH first, fT4 & fT3 if indicated)

OTHER CHEMISTRY TESTS

- [X] Sodium
- [X] Potassium
- [ ] Albumin
- [ ] Alk phos
- [X] ALT
- [ ] B12
- [ ] Bilirubin
- [ ] GGT
- [ ] T. Protein
- [X] Creatinine / eGFR
- [ ] Calcium
- [X] Creatine kinase (CK)
- [ ] PSA – Known or suspected prostate cancer (MSP billable)
- [ ] PSA screening (self-pay)
- [ ] Pregnancy test
- [ ] ß-HCG – quantitative

OTHER TESTS – Standing Orders Include expiry & frequency

- [ ] ECG
- [ ] FIT (Age 50-74 asymptomatic q2y) Copy to Colon Screening Program
- [ ] FIT No copy to Colon Screening Program

Lp(a) - for risk stratification
Fasting 8-10 hours
For non-ER Chest Pain Clinic Referrals

SIGNATURE OF PRACTITIONER | DATE SIGNED

DATE OF COLLECTION | TIME OF COLLECTION | COLLECTOR | TELEPHONE REQUISITION RECEIVED BY: (employee/date/time)

INSTRUCTIONS TO PATIENTS (See reverse)
Other Instructions:

The personal information collected on this form is collected under the authority of the *Personal Information Protection Act*. The personal information is used to provide medical services requested on this requisition. The information collected is used for quality assurance management and disclosed to healthcare practitioners involved in providing care or when required by law. Personal information is protected from unauthorized use and disclosure in accordance with the *Personal Information Protection Act* and when applicable the *Freedom of Information and Protection of Privacy Act* and may be used and disclosed only as provided by those Acts.

Chest Pain Clinic
St. Paul's Hospital
200 - 1033 Davie Street
Vancouver, BC, V5E 1M7
T: 604-296-0655
F: 604-689-4219
E: ChestPainClinic@providencehealth.bc.ca

Date: ____________________

INITIAL CONSULTATION

This form is designed to help us treat you better. Please complete as best as you can before your visit.

Full Name: ____________________________________ **Age**: ______ **Date of birth**: ______________

Referring Dr. ______________________________ **Family Dr.** ______________________________

Height: ___________ **Weight**: ___________ **Email**: ____

Details of prior heart problems, including heart attacks, admissions to hospital with heart issues, heart surgery, or angioplasty (stents), and names of specialists:

Year	Heart Problem or Procedure	Doctor (Specialist)

Details of any heart tests in the past, including exercise (treadmill) stress tests, nuclear tests (MIBI), echocardiogram (ultrasound), heart CT (CAT scan) or catheterization (coronary angiogram):

Year	Heart Test	Doctor (Specialist)

Medications:
Please list (or attach) all medications, doses, frequency, including aspirin, vitamins, herbal remedies:

Allergies:
Are you allergic to any medications? ☐NO ☐YES - please list medication and reaction:

Please turn over ➔

What is the main reason that you were referred to see us?

Other current symptoms:

Chest pain

Do you have chest pain? ☐NO ☐YES - Since when? ___________

Describe the chest pain: ☐Sharp ☐Heavy ☐Pressure ☐Burning
☐Dull ache ☐Tight ☐Other (describe): ______________________

Where do you feel the pain? ☐Left side of chest ☐Right side of chest
☐Back ☐Middle of chest

Does the pain move anywhere else? ☐NO ☐Down arm (L or R) ☐To jaw / neck
☐To back ☐Other (describe): ______________________________

What brings on the pain? (eg: exercise, stress) ______________________

How long does it last each time? ___________**minutes** OR ___________**hours**

What relieves the pain? (eg: rest, nitroglycerin) ______________________

How often does it occur? ___________**per day** OR ___________**per week** OR ___________**per month**

Shortness of breath

How long can you walk on a flat surface or flight of stairs without stopping?

___________**blocks** OR ___________**minutes** OR ___________ **flights of stairs**

What makes you stop? ☐Fatigue ☐Chest pain ☐Shortness of breath
☐Leg/back pain ☐Other (describe): ______________________________

Do you have shortness of breath? ☐NO ☐YES - When is it present?
☐Most of the time ☐Just with exertion

Do you feel short of breath when you lie flat in bed? ☐NO ☐YES

How many pillows do you sleep with under your head? ☐0-1 ☐2-3 ☐≥4 or other: ___________

Do you wake up at night short of breath? ☐NO ☐YES - How many times a week on average? _____

Do you have swelling of the ankles? ☐NO ☐YES - Since when? ___________

Claudication

Do you have pain / aching in your leg muscles when you walk? ☐NO ☐YES - Since when? _______

If yes, where do you feel it? ☐Left leg ☐Right leg ☐Both legs
☐Calf ☐Thigh ☐Buttock

If yes, does it go away when you rest? ☐NO ☐YES

Palpitations

Do you feel palpitations (awareness of your heartbeat)? ☐NO ☐YES - please describe: (eg: how long they last, fast or slow, regular or irregular): ____

Other

Do you ever pass out? ☐NO ☐YES - When was the last time? ___________

How often does it occur on average? ___________**per week** OR ___________**per month**

Do you ever feel lightheaded? ☐NO ☐YES - Please describe: (eg: spinning, feeling faint, imbalance, on standing, after moving head fast): ____

Any other current symptoms or problems that you have not yet described?

Risk factors for heart disease:

Have you ever smoked regularly? ☐NO ☐YES
If yes, do you currently smoke? ☐NO ☐YES
What was the most number of cigarettes you smoked per day? ___________
When did you quit? _____________________

Do you drink alcohol? ☐NO ☐YES
If yes, how many drinks on average **per day**? ___________ OR **per week**? ___________
Did you previously drink heavily? ☐NO ☐YES
If yes, what was the most per week? ___________

Do you use recreational drugs? ☐NO ☐YES
If yes, please list what you currently use / have used: ____________________________________
When was your last use? _____________________

How many caffeinated drinks (coffee, tea, Cola) do you drink **per day**? _______OR **per week**? _______

Have you ever been diagnosed with diabetes? ☐NO ☐YES - What year? ___________
Do you have any complications from diabetes? ☐NO ☐YES
If yes: ☐Kidneys ☐Eyes ☐Numbness of hands / feet ☐Other: ____________

Have you ever been diagnosed with high blood pressure? ☐NO ☐YES - What year? ___________
What has your BP averaged lately? _____________________

Have you ever been diagnosed with high cholesterol? ☐NO ☐YES - What year? ___________

Do you exercise regularly at home or work for a minimum of 20 mins 3 times a week? ☐NO ☐YES

What is your stress level? ☐LOW ☐MEDIUM ☐HIGH

Do you follow a particular diet? ☐NO ☐YES - Please describe: ___________________________

Do your close family members have heart issues (hardened arteries, rhythm issues, unexpected death before 60 years old)? ☐NO ☐YES - Please provide details of diagnosis, age of onset, age of death:

Father:	Brother(s):	Son(s):
Mother	Sister(s):	Daughter(s):

Past Medical History:
Any history of asthma (or ever needed to use an inhaler)? ☐NO ☐YES
Any history of kidney problems? ☐NO ☐YES
Any history of bleeding or stomach ulcers? ☐NO ☐YES

Apart from the answers above, list year and diagnosis of any other medical conditions, hospitalizations, pregnancies, complications of pregnancy, or surgeries:

Year	Diagnosis	Doctor (Specialist)

Please turn over ➔

Social and Family History:

Where were you born? ________________________
If other than BC, when did you move to BC? _____________________

Current marital status: ☐Single ☐Married ☐Common-law ☐Same-sex relationship
☐Widowed ☐Separated ☐Divorced ☐Other: _________________

How many biological children do you have? ___________

Employment status: ☐Currently employed ☐Retired ☐Semi-retired
☐Looking for work ☐On disability since: ___________
Current or Previous Occupation: _____________________

Do you have any questions you would like to ask me?

Thank you for taking the time to complete this form. It provides us with helpful information and allows us to spend more time discussing relevant matters with you.