Print Clear Form

Providence HEALTH CARE

HEART CENTRE

Place Patient Form Label Here

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

* 1 0 0 0 4 *

Cardiology Referral

St. Paul's Hospital Chest Pain Clinic
Address: Suite 200 – 1033 Davie Street, Vancouver, BC V6E 1M7
Phone: 604-296-0655 **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
☐ Diabetes
☐ Dyslipidemia
☐ Currently smokes
☐ Family history of early atherosclerosis
☐ 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
☐ CCTA
☐ None
☐ P-MIBI
☐ Stress Echo

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.

Providence HEALTH CARE
How you want to be treated.

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

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

ADDRESS OF PATIENT	CITY/TOWN	PROVINCE	POSTAL CODE
		BC	

DIAGNOSIS

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

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

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

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:

Providence HEALTH CARE

SPH CHEST PAIN CLINIC QUESTIONNAIRE

* 1 0 3 1 9 *

Medical Questionnaire

St. Paul's Hospital Chest Pain Clinic
200 - 1033 Davie Street, Vancouver, BC, V5E 1M7
Phone: 604-296-0655 FAX: 604-689-4219
Email: ChestPainClinic@providencehealth.bc.ca

Please complete this questionnaire as best as you can before your visit. Your answers will help us better treat you.

Date: _____

Full Name: _____ Age: _____ Date of birth: _____

Referring Dr. _____ Family Dr. _____

Height: _____ Weight: _____ Email: _____

MEDICAL HISTORY

Please tell us about any previous **heart problems or procedures**, including heart attacks, hospital stays for heart issues, heart surgery, or angioplasty (stents). Include the date and the name of specialists:

Year	Heart Problem or Procedure	Doctor (Specialist)

Please tell us about any **heart tests** you have had 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)

Do you have any history of asthma (or ever needed to use an inhaler)? ☐ NO ☐ YES

Do you have any history of kidney problems? ☐ NO ☐ YES

Do you have any history of bleeding or stomach ulcers? ☐ NO ☐ YES

Do you have any **other medical conditions** or have you had any **other procedures** that are not mentioned above, including hospitalizations, complications of pregnancy, or surgeries? Include the year and name of specialist(s):

Year	Diagnosis	Doctor (Specialist)

MEDICATIONS:

Please list all medications you are currently taking or attach a list. Include over the counter medications (e.g. ASPIRIN, TYLENOL), vitamins, and herbal remedies. Include the dose and how often you take it.
Please use the last page if you need more space.

ALLERGIES:

Are you allergic to any medications? ☐ NO ☐ YES - please list the medication(s) and your reaction below.

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? (date) _____

Do you drink alcohol? ☐ NO ☐ YES

If yes, how many drinks on average **per day**? _____ OR **per week**? _____

Have you ever been a heavy drinker? ☐ 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? (date) _____

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, are the complications with: ☐ 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 for a minimum of 20 minutes 3 times a week? ☐ NO ☐ YES

How would you describe your level of stress? ☐ Low stress ☐ Medium stress ☐ High stress

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

Have any immediate family members had heart issues before age 60? (hardened arteries, rhythm issues, unexpected death) ☐ NO ☐ YES – Provide diagnosis, age of onset, age at death (if relevant)

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

Providence HEALTH CARE

SPH CHEST PAIN CLINIC QUESTIONNAIRE

* 1 0 3 1 9 *

Medical Questionnaire

WHAT IS THE MAIN REASON THAT YOU HAVE BEEN REFERRED TO THE CHEST PAIN CLINIC?

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 is the pain? ☐ Left chest ☐ Right chest ☐ Middle of chest ☐ Back

Does it travel to other areas? ☐ NO ☐ YES ☐ To jaw / neck ☐ Down arm (L or R) ☐ To back ☐ Other (describe): _____

What brings on the pain? (e.g. exercise, stress) _____

How long does the pain last each time? _____ **minutes** OR _____ **hours**

What relieves the pain? (e.g. rest, nitroglycerin) _____

How often does the pain occur? _____ x **per day** OR _____ x **per week** OR _____ x **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 ☐ Shortness of breath ☐ Chest pain ☐ Leg/back pain ☐ Other (describe): _____

Do you have shortness of breath? ☐ NO ☐ YES

When is it present? ☐ Most of the time ☐ Just with exertion ☐ When I lie down

How many pillows do you sleep with under your head? ☐ 0-1 ☐ 2-3 ☐ 4 or more

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 *(leg pain)*

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 ☐ Calf ☐ Thigh ☐ Buttock

Does it go away when you rest? ☐ NO ☐ YES

Palpitations *(noticeable rapid, strong or irregular heartbeat)*

Do you ever feel palpitations? ☐ NO ☐ YES - please describe: _____

_____

(e.g. how long they last, fast or slow, regular or irregular)

Other

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

Do you ever feel lightheaded? ☐ NO ☐ YES - describe _____

(e.g. spinning, feeling faint, imbalance, on standing, after moving head fast)

Do you have any other current symptoms you have not yet described: _____

SOCIAL HISTORY:

This information helps us understand your home and personal background, and any possible effect on your health or medical conditions.

Where were you born? _____

If other than BC, when did you move to BC? (date) _____

Current marital status: ☐ Single ☐ Married ☐ Common-law ☐ Divorced ☐ Separated ☐ Widowed ☐ Other: _____

Sexual Orientation: ☐ Heterosexual ☐ Same-sex ☐ Bisexual ☐ Other: _____ ☐ Prefer not to answer

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 us?

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

ADDITIONAL NOTES