**GP Adult Cardiology Diagnostic Referral**

**Please select one of the sites below and send the referral to the corresponding email address**

**Queen Mary’s Hospital**

**Phone:** *0208 487 6482*

**Email:** *stgh-tr.qmhcardiologydirectaccess@nhs.*net

**Nelson Health Centre**

**Phone:** *0203 668 3336*

**Email:** *stgh-tr.ref1@nhs.net*

**St George’s Hospital**

**Phone:** *0208 725 1184*

**Email:** *cardiac.investigationreferrals@nhs.net*

**ALL PATIENTS MUST BE 18+**

**This form is for Diagnostic referrals only. Consultation referrals must be via E-RS.**

**Forename: Surname: Date of Referral:**

**DOB: NHS no: Gender: Male** **Female** **Other**

**GP details:**

**GP Email:**

**Address:**

**Home Tel:**

**Mobile Tel:**

**Medical History:**

**Existing IHD Smoking HX Diabetes Hypertension Hyperlipidaemia Family HX**

**\*Heart Failure Guidance**

**Individual Diagnostic Tests**

**Individual Diagnostic Tests**

**\*\*Please note, if heart failure is suspected, request NTproBNP.**

**- If NTproBNP>400ng/L refer to rapid access HF clinic.**

**- If NTproBNP <400ng/L reconsider other diagnoses and only request echo if suspicion of cardiac disease remains.**

**ECG** **[*Walk-in service* Mon-Fri 9:30-4pm]**

***(Not for Wandsworth Patients)***

**Echo [*See HF Guidelines if relevant*]\***

**24hr ECG**

**24hr BP Monitor (QMH Site Only)**

**Please specify clinical history and reason for referral:**

***Referrer Name: Date:***