Family Heart Screening GP Referral Form

Please fill in page one only

Date:		**Family No:** *(if known)*	
First Name:		**Surname:**	
Date of Birth:		**Email Address:**	
MRN: *(if known)*		**Tel - Home:**	
Address:		**Tel - Mobile:**	
		Other:	
GP Name:		**GP Tel:**	

Reason for Referral: *e.g. family hx SADS / DCM/ HCM / ACM / LQT S/ Brugada / CPVT.*	
Known Gene variant in family	Yes ☐ No ☐ Gene: ____________________ **Please attach familial report if available**
Coroner's Report Available? *Please attach if available*	Yes ☐ No ☐
Patient Health History: *Include:* • *previous illnesses* • *surgeries,* • *hospitalisations,* • *faints,* • *syncope,* • *palpitations,* • *chest pain* • *current medication list*	
Family Health History: *e.g. who in the family suffers from this condition (if anyone)* *e.g. any family history you think relevant*	

Family Heart Screening
GP Referral Form

Below for Use in Heart House FHSC - Please Scan to Patient Centre as a Referral

<table>
<tr><td>Date Referral Received:</td><td colspan="3"></td></tr>
<tr><td>Is this Referral appropriate for FHSC?</td><td colspan="3">Yes ☐ If Yes, proceed to Booking
No ☐ If No, return to Referrer or refer on as appropriate</td></tr>
<tr><td rowspan="3">Booking Requirements</td><td colspan="3"><u>Time frame</u> for referral to be seen: ASAP ☐ Soon ☐ Routine ☐</td></tr>
<tr><td colspan="3">Clinician to Book into:
JG CMcG REG ED (ANP) Any
ONE DAY ☐ Two days ☐</td></tr>
<tr><td colspan="3">Testing required for Appointment:
ECHO ☐ ECG ☐ Holter ☐ ETT ☐ High lead ECG ☐
Genetics ☐</td></tr>
<tr><td>Any other Requirements Pre-Clinic Review?</td><td colspan="3"></td></tr>
<tr><td rowspan="2">Triaged by:</td><td>Consultant:</td><td></td><td rowspan="2">STAMP

SCANNED</td></tr>
<tr><td>Nurse:</td><td></td></tr>
</table>

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