

PALPITATIONS/SUSPECTED ARRHYTHMIA (PALS) REFERRAL

Use SCI Gateway Form unless the gateway unavailable

Patient Details

Name..... GP Name.....

Address..... Practice Code.....

..... Tel No..... Fax.....

Tel No.....DoB..... CHI Number.....

Interpreter required? Y N If Y spoken language

Preferred hospital (please circle) GRI WIG IRH RAH VoL Victoria Stobhill Southern Gen

Preferred hospital will be offered for appointment unless (unusually) waiting time guarantee cannot be met

Aims of Palpitations service

- To provide a safe, streamlined service for patients with palpitations and rapid reassurance for the 95% or so of the patients who have no cause for alarm.
- It will also free up clinic slots in general cardiology clinics for more rapid access for potentially more serious problems.
- This is NOT an urgent service.
- Patients with palpitations associated with **loss of consciousness** should have an URGENT medical cardiology clinic referral - **do not use this service**.
- If known or suspected AF do not use this service - see [AF Guideline](#).
- Please advise patients to bring all their medicines with them to the appointment.

CLINICAL INFORMATION

This is requested to help us choose the most appropriate investigations for your patient

Previous referral to palpitations service? Y N

If Yes, add date..... Which hospital.....

Previously documented arrhythmia? Y N

If Yes, which:	atrial premature beats <input type="checkbox"/>	ventricular premature beats <input type="checkbox"/>
	atrial tachycardia <input type="checkbox"/>	ventricular tachycardia <input type="checkbox"/>
	atrial flutter <input type="checkbox"/>	ventricular fibrillation <input type="checkbox"/>
	atrial fibrillation: - Do not refer to this service for diagnosis - see AF Guideline	torsade de pointes <input type="checkbox"/>
		supraventricular tachycardia <input type="checkbox"/>
		other <input type="checkbox"/>

Echocardiogram in past year? Y N

If Yes, add date Which hospital.....

Please append copy of echo report if you have one

Pulse rate...../min: Reg Irreg

Frequency of palpitations (please tick one)

>1 episode per day < 1 episode per day but > 1 episode per week < 1 episode per week

Please append repeat prescribing print-out. Ensure dose and frequency appear on list.

Any other relevant information.....

- All information should be completed to ensure a safe and efficient service is provided to your patient.
- **Please Fax form to 232 1020** An appointment will be sent to your patient
- Telephone number for central booking office 0141 232 0793

Signature of Referring GP.....Date.....