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CHEST PAIN CLINIC

Patient Information

Label Here

Referring Physician

Date:

Physician name:

Physician address:

Physician number:

Physician signature:

Considered a valid prescription when signed by a physician

Copies to:

Urgency

☐ 24 hrs ☐ 48 hrs ☐ 72 hrs ☐ 1 Week

Chest Pain Rating

Angina ☐ Typical ☐ Atypical

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Medical History

Check All That Apply

- ☐ Diabetes
- ☐ Hypertension
- ☐ Hyperlipidemia
- ☐ Known CAD
- ☐ Smoker ☐ Past ☐ Current
- ☐ Strong Family History of Heart Disease
- ☐ Abnormal ECG
- ☐ Abnormal Stress Test
- ☐ Abnormal Coronary CT
- ☐ History of Myocardial Infarction
- ☐ History of Heart Failure
- ☐ Peripheral Artery Disease
- ☐ History of COPD
- ☐ Atrial Fibrillation
- ☐ Palpitation
- ☐ History of CABG
- ☐ History of Valvular Surgery
- ☐ Shortness of Breath
- ☐ Obstructive Sleep Apnea

Additional Information / Report Attached

☐ ECG ☐ Lab ☐ Stress Test ☐ Echo ☐ MPI

☐ X-Ray ☐ CT ☐ MRI ☐ Holter ☐ 24ABP