

**SURNAME:**

**GP DETAILS:**

**FIRST NAME:**

**GP PRACTICE CODE:**

**DATE OF BIRTH:**

**FAX NO:**

**ADDRESS:**

**NHS/PRIVATE:**

**PHONE NO.**

**MALE / FEMALE**

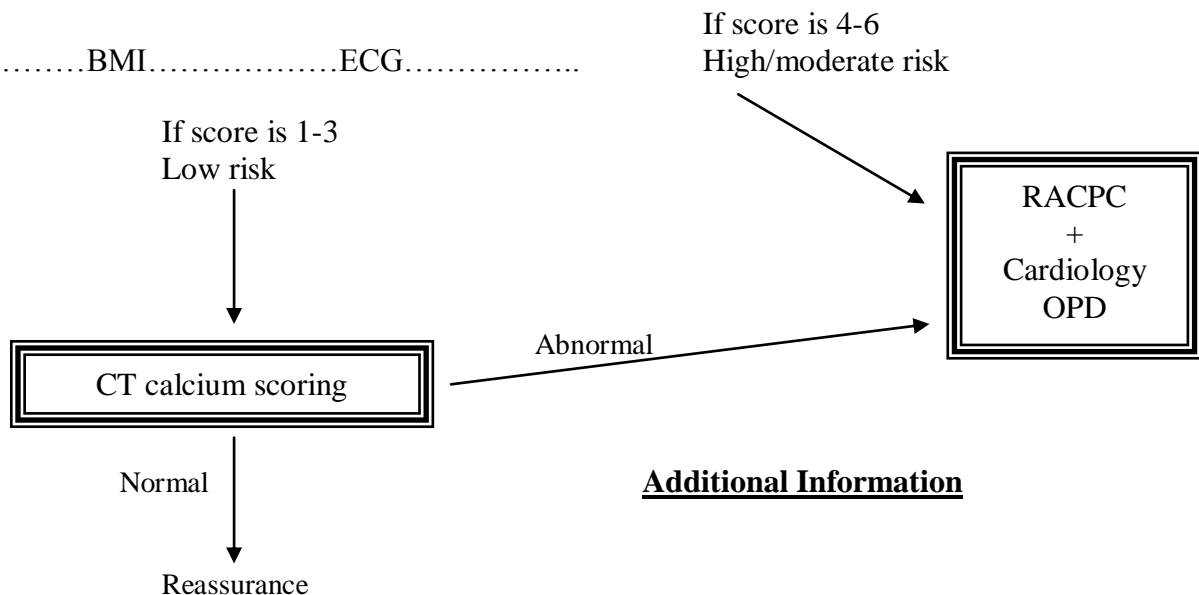
**NHS NO.**

**PATHWAY FOR CT CALCIUM SCORING FOR GP PATIENTS - Please tick boxes below**

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
No Symptoms	Short of Breath	Atypical Chest Pain	Stable Angina	Unstable Angina	MI
↓				↓	
<input type="checkbox"/>	Past Medical History of IHD	<input type="checkbox"/>	Raised Cholesterol	A&E Immediate Referral	
<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Smoker		
<input type="checkbox"/>	Raised BP	<input type="checkbox"/>	Family History IHD		

(One point scored for each of the above boxes ticked)

Age.....BMI.....ECG.....



**Additional Information**

**GP SIGNATURE.....**