

Chest Pain Assessment Unit

Prompt & Comprehensive Assessment
Rapid access to Cardiology services



Services Provided

- Resting ECG.
- Physical examination and clinical history.
- Biochemical markers for myocardial ischaemia, if appropriate.
- Non-invasive testing e.g. treadmill exercise test, echocardiography, dobutamine stress echo.
- Review of patient by Cardiologist & formulation of management plan.
- Patient education with Chest Pain Nurse.

Referral Process

GP referral letter is required. Please advise patients to bring CD / video of any previous angiograms.

Urgent Chest Pain

- Contact Chest Pain Nurse for immediate access 01 885 8888 (ask for bleep 8407).
- Same day assessment organised if required.

Non-Urgent Chest Pain

- Contact Cardiology Outpatient Appointments 1800 200 550.
- Post or fax referral letter specifying Chest Pain Service.
- Assessment within 1 week of referral.

Patient Referral Criteria

Patients with symptoms suggestive of unstable angina / acute coronary syndrome will be admitted on the day for possible coronary intervention.

Symptomatic

- Recent onset chest pain presumed cardiac in origin.

Elderly or Diabetic

- New onset exertional dyspnoea suggestive of angina.

Post Cardiac Intervention

- New or recurring cardiac symptoms. Known Cardiac Disease -Worsening or Accelerate angina.

Chest Pain Assessment Unit
Mater Private Hospital
Eccles St, Dublin 7

Routine Referrals
Mon – Fri: 8am – 6pm
Freephone: -1800 200 550
Fax: -01 885 8150

Urgent Referrals
Mon – Fri: 8am – 8pm
Tel: -01 885 8888 bleep 8407
Fax: -01 885 8150



Chest Pain Assessment Unit

Referral Form



Practice Details

GP Name: _____

Address: _____

Tel: _____

Fax: _____

Referring GP signature: _____

Patient Details

Name: _____

Address: _____

Tel: _____

Mobile: _____

Date of Referral: _____

Patient History

Reason for Referral: _____

Current Medication: _____

Please include the following information if known:

Cholesterol:	Date Taken: _____	HDL:	Date Taken: _____
Glucose:	Date Taken: _____	LDL:	Date Taken: _____
HbA1C:	Date Taken: _____	TG:	Date Taken: _____
Hb:	Date Taken: _____		
ECG:	Date Taken: _____		

Past Medical History / Additional Information: _____

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