**Cardiomyopathy Teleconsultation Protocol**

**----- Part 1: Patient and nurse -----**

**Step 1:** Patient got an appointment through the hospital

**Step 2:** Patient signs up on our portal

**Step 3:** Patient signs in

**Step 4:** Patient fills-up symptoms form. Here, the patient will have web resources and a nurse calling facility

**Step 5:** Patient submits symptoms form

**----- Part 2: Patient and doctor -----**

**Step 6:** Doctor signs in

**Step 7:** Doctor sees the patients’ list and click on the patient name

**Step 8:** Doctor reads symptoms form

**Step 9:** Doctor calls patient

**Step 10:** Doctor and patient have a video call. Meanwhile, doctor adds the assessment details in the form.

**----- Part 3: Doctor -----**

**Step 11:** Doctor saves the assessment details

**Step 12:** Doctor verifies the complete form

**Step 13:** Doctor generates a letter

**Step 14:** Doctor verifies the letter and amends it

**Step 15:** Doctor prints PDF and emails it to the patient

**Patient sign up**

|  |  |
| --- | --- |
| First Name |  |
| Last Name |  |
| Email |  |
| Contact Number |  |
| Password |  |
| Confirm Password |  |

**Patient sign in**

|  |  |
| --- | --- |
| Email / Contact number |  |
| Password |  |

**Patient Dashboard**

Follow-up patient

New patient

**Patient symptoms form**

1. **Diagnoses**

(Please write about your diagnoses.)

1. **PMHx : Past medical history**

(Please enter your past medical history.)

1. **CP: Chest pain**

(Please select ‘Yes’ if you feel chest pain.)

**Yes No**

If selected ‘Yes’, please write below details.

1. **How many times do you feel chest pain in a day?**

**<5 5-10 >10**

1. **Where about in the chest do you feel pain?**

**Centre Left Right**

1. **How long does the chest pain last for?**

**< 5 minutes 5-10 minutes >10 minutes**

1. **What causes you chest pain?**

Please write

1. **Does anything make chest pain better?**

Please write

1. **Have you seen anyone about your chest pain?**

Please write

1. **Other**

Is there anything else about your chest pain that you would like to mention? Please write.

1. **T: Tightness**

(Do you feel tightness? To know about tightness, please click here.)

**Yes No**

1. **P: Pulpitations**

(Do you feel pulpitations? To know about pulpitations, please click here.)

**Yes No**

1. **SOB: Shortness of breath**

(Please select ‘Yes’ if you feel shortness of breath (SOB).)

**Yes No**

If selected ‘Yes’, please write below details.

1. **How often do you feel SOB?**

**All the time Sometimes only**

1. **What makes SOB better?**

Please write

1. **What makes SOB worse?**

Please write

1. **Was there a cause for SOB?**

Please write

1. **Other**

Is there anything else about feeling shortness of breath that you would like to mention? Please write.

1. **O: Orthopnea**

(Do you feel orthopnea? To know about orthopnea, please click here.)

**Yes No**

1. **PND: Paroxysmal nocturnal dyspnea**

(Do you feel paroxysmal nocturnal dyspnea (PND)? To know about PND, please click here.)

**Yes No**

1. **SOA: Swelling of ankles**

(Do you suffer swelling of ankles?)

**Yes No**

1. **C: Coughing**

(Do you feel coughing?)

**Yes No**

If selected ‘Yes’, please write below details.

1. **How often do you cough?**

**All the time Sometimes only**

1. **W: Wheezing**

(Do you feel wheezing? To know about wheezing, please click here.)

**Yes No**

1. **S: Sputum**

(Do you get sputum?)

**Yes No**

1. **D: Dizziness**

(Do you feel dizziness? To know about dizziness, please click here.)

**Yes No**

1. **PRE: Presyncope**

(Do you feel presyncope? To know about presyncope, please click here.)

**Yes No**

1. **Tiredness**

(Do you feel tired all the time?)

**Yes No**

1. **Exercise**

(Do you do exercise regularly?)

**Yes No**

If selected ‘Yes’, please write below details.

1. **How many days in a week do you do exercise?**

Please write

1. **For how many minutes do you exercise each day?**

Please write

1. **Other**

Would you like to share any other symptoms? Please write.

1. **Other**

Would you like to share any other symptoms? Please write.

1. **Other**

Would you like to share any other symptoms? Please write.

1. **CNS: Central nervous system**

(Do you have central nervous system (CNS) difficulties? To know about CNS, please click here.)

Please write

1. **MSK: Musculoskeletal**

(Do you have musculoskeletal (MSK) difficulties? To know about MSK difficulties, please click here.)

Please write

1. **GI: Gastrointestinal**

(Do you have gastrointestinal (GI) difficulties? To know about GI difficulties, please click here.)

Please write

1. **UGS: Urogenital symptoms**

(Do you have urogenital symptoms (UGS) difficulties? To know about UGS, please click here.)

Please write

1. **Skin**

(Do you have skin issues?)

Please write

1. **Gynae**

(Do you have gynae difficulties?)

Please write

1. **Meds: Medications**

(Are you on medications?)

**Yes No**

If selected ‘Yes’, please write below details.

1. **What medicine do you take?**

Please write

1. **Why do you take medication?**

Please write

1. **How long have you been taking medication for?**

Please write

1. **How often do you take medication?**

Please write

1. **What dose do you take?**

Please write

1. **Other**

Would you like to share anything else about your medication? Please write.

1. **Drug allergies**

Do you have any drug allergies? Please write.

1. **Updates**

Would you like to share any updates since your last visit? Please write.

1. **RF: Risk factors**

(Please share if you have below habits.)

1. **Do you smoke?**

**Yes No**

1. **Do you drink?**

**Yes No**

1. **What is your diet like?**

Please write

1. **FHx: Family History**

Does any of your blood relative has cardiovascular disease? Please write. Otherwise, please write NA.

1. **Invs: Interventions**

Would you like to share any interventions that you underwent? Please write. Otherwise, please write NA.

1. **New tests**

Have you had any new tests since your last visit? Please write. Otherwise, please write NA.

Submit

**Doctor sign in**

|  |  |
| --- | --- |
| Email / Contact number |  |
| Password |  |

**Doctor’s Dashboard**

**Patients’ list**

1. Mr A B C
2. Mr X Y Z
3. Mr P Q R

**Patient’s assessment form**

1. **Blood sample**

(Please write about your blood sample report.)

1. **ECG: Electrocardiogram**

(Please write ECG findings.)

1. **Echo: Echocardiogram**

(Please write Echo findings.)

1. **CMR: Cardiac magnetic resonance**

(Please write CMR findings.)

1. **Holt**

(Please write Holt assessment.)

1. **Pacemaker**

(Please write about pacemaker.)

1. **ETT: Exercise tolerance test**

(Please write about exercise tolerance test.)

1. **CT: Computed tomography**

(Please write CT findings.)

1. **Other**

(Please write about any other findings.)

1. **OE: On examination**

(Please write about on examination findings.)

1. **BP: Blood pressure**

(Please write about blood pressure report.)

1. **HR: Heart rate**

(Please mention heart rate.)

1. **Wt: Weight**

(Please mention weight in pounds.)

1. **Plans**

(Please write plan.)

1. **NB: Nota bene**

(Please note well!)

1. **Ask about**

(Please write specifics.)

1. **Main diagnosis**

(CMR MVO2 Holter 24/7d Stress Echo Bloods)

1. **MD tests required**

(Please mention further tests required.)

1. **MD treatment plan**

(Dose uptitration, SGLT2, Entresto.)

1. **Risk strat**

(Fab 4: Fluids/ Wt/ BB/ Salt.)

1. **Device or arrythmia risk issues**

(Driving and DVLA.)

1. **Device or arrythmia risk issues**

(Anticoagulation?)

(?Reduce dose if renal failure)

1. **Device or arrythmia risk issues**

(HAS BLED SCORE)

(?lansoprazole)

1. **Device or arrythmia risk issues**

(?ICD)

1. **Pacemaker**

(?Discharge)

**Yes No**

1. **Pacemaker**

(Date of next follow up)

1. **Genetics**

(?Refer to Tessa/Sam)

1. **BPr**

(Blood pressure recorder)

1. **Lipid**

(Please mention about lipid.)

1. **Family screening**

(Family screening)

1. **Chase**

(Please chase)

1. **Diagnosis other**

(Please mention other diagnosis)

1. **COVID**

(COVID Advice given)

1. **Dental check?**

(Dentist appointment)

1. **Lifestyle**

(Do you exercise?)

1. **Lifestyle**

(Alcohol and smoking)

1. **Lifestyle**

(DTF)

1. **Lifestyle**

(Dt)

1. **Pregnancy**

(? Stop ACE/ARB)

1. **Pregnancy**

(? Stop meds)

1. **Pregnancy**

(OCP/Card preg service)

1. **Patient education**

(CMUK)

1. **Patient education**

(BHF)

1. **Red flags**

(Symptoms to prompt expedited follow up inc)

1. **Follow up plan + next steps arrange**

(Please mention.)

1. **Follow up plan + next steps**

(Call after tests)

1. **Follow up plan + next steps**

(Time of follow up)

1. **Follow up plan + next steps**

(? For MDT)

1. **Follow up plan + next steps**

(cc)

1. **Follow up plan + next steps**

(? For red flags list)

Submit

Email PDF

Generate letter

Amend and approve letter