**Cardiac Sarcoidosis Service Referral Form**

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|  |  |  |  |
| **Patient Name:** |  | **Referring Hospital:** |  |
| **Date of Birth:** |  | **Referring Consultant:** |  |
| **Gender:** |  | **Referrer Email**  **(Secure e.g. nhs.net):** |  |
| **NHS Number:** |  |  |
| **Referral Date:** |  | **Contact Number:** |  |
|  |  |  |  |

**New presentation of suspected CS or known CS?**

**Already known to RBH? YES / NO**

**Current presenting history:**

**Past Medical history:**

**Current medication (dose and frequency):**

**Is there confirmation of extra-cardiac sarcoidosis? YES / NO**

**If YES: specify details (Biopsy proven? Clinical diagnosis? Date of diagnosis)**

**Device in situ? YES / NO**

**If YES: please provide the type of device (PPM, ICD, CRT-P, CRT-D) and year of implant:**

**Question for the MDT:**

**Investigations (Please ensure the relevant imaging is sent to Royal Brompton Hospital PACS):**

TTE Study date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Report:

CMR Study date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Report:

FDG PET/CT Study date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Report:

Other relevant investigations Study date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Report: