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| **Elective Cardiac Surgery Referral** |
| **Date of referral:**  Click here to enter text. |
| **MINIMUM DATA SET****(\*Referral without complete information will be refused)** |
| **PATIENT DETAILS\*** |
| **First name** |  Click here to enter text.  | **Phone number** |  Click here to enter text.  |
| **Surname** |  Click here to enter text.  | **Address** |  Click here to enter text.  |
| **NHS number** |  Click here to enter text.  |
| **Date of birth** |  Click here to enter text.  | **Email** |  Click here to enter text.  |
| **REFERRER DETAILS\*** |
| **Referring clinician** |  Click here to enter text.  | **Clinical priority** |  P2[ ]  P3[ ] P4[ ]  (please note all P1 (urgent) referrals should be made via Telelogic) |
| **Referring centre/ hospital** |  Click here to enter text.  | **Presenting complaint/ diagnosis** |  Click here to enter text.  |
| **Referrer’s email** |  Click here to enter text.  | **State the procedure for which you are referring for consideration** |  Click here to enter text.  |
| **Sub-speciality** |  Click here to enter text. |
| **IMAGING & INVESTIGATIONS\*** |
| **Angiogram findings** |  Click here to enter text.  | **Serum creatinine (if known** |  Click here to enter text.  |
| **ECG findings** |  Click here to enter text.  | **Blood haemoglobin (if known)** |  Click here to enter text.  |
| **Other cardiac investigations (CT, CMR, MPS)** |  Click here to enter text.  | **Carotid studies (if known)** |  Click here to enter text.  |
| **Echocardiogram findings** |  Click here to enter text.  | **Spirometry (if known)** |  Click here to enter text.  |
| **Has imaging been transferred?** | Y [ ]  N [ ]  Click here to enter text. |
| **ADDITIONAL MANDATORY INFORMATION\*** |
| **Known risk factors** |  Click here to enter text.  | **Interpreter Required?** | Y [ ]  N [ ]  *If yes, language spoken:*  Click here to enter text. |
| **Relevant co-morbidities** |  Click here to enter text.  | **Was the patient discussed with a cardiac surgeon?** | Y [ ]  N [ ]   *If yes, who:*  Click here to enter text. |
| **Previous cardiac history** |  Click here to enter text. | **Local MDT outcome if discussed and any further comments** |  Click here to enter text.  |
| **ADDITIONAL NON-MANDATORY INFORMATION** |
| **Accepting surgeon (if known)** |  Click here to enter text.  | **GP phone number** |  Click here to enter text.  |
| **GP name & practice** |  Click here to enter text.   | **Patient height** |  Click here to enter text.  |
| **Patient weight** |  Click here to enter text.  |
| Once all fields are complete, email this form, **attaching all appropriate reports,** to the generic email address below. Please remember that **referrals without complete minimum data set will be rejected.****Please add the procedure or surgeon you are referring to in the subject header of the email.** |
| **EMAIL** |  rbh-tr.cardiacreferrals@nhs.net  |
| **REFERRAL ACCEPTANCE (INTERNAL USE ONLY)** |
| **Date Referral Received** |  Click here to enter text.  | **Date Referral Accepted** |  Click here to enter text.  |
| **Date uploaded to Lorenzo/ EPIC** |  Click here to enter text.  |