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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 P3P4  (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](mailto: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. | | | | | |