Castle Hill. Referral for in-patient cardiac surgery (to on-call consultant cardiothoracic surgeon)

Please note: this is a preliminary minimum information request. Incomplete information may delay the acceptance of patients for surgery or result in last-minute cancellations and the loss of valuable operating theatre time. Thank You.

Fax to: 01482 623257. On-call registrar tel. 01482875875 bleep 655.

Surname	
Forename	
Date of Birth	
NHS Number	

Referring Hospital	
Patient location / ward	
Contact details	
Cardiologist responsible	

Diagnosis / reason for referral / request	□ Endocarditis (include culture and antibiotic details)
Angiography findings	Angiogram date:
Echo findings	Echo date:

Ejection fraction: %	eGFR:	Urea:	Creatinine:
Hb:	WBC:	Platelets:	
Height: m	Weight: Kg	BMI:	

□ Aspirin	□ steroids	□ methotrexate	Other drugs
□ Clopidogrel, Prasugrel, ticlopidine, ticagrelor	□ g2a3b inhibitors (tirofiban, etc.)	□ warfarin or other oral anticoagulants	

MRSAstatus	Pos	Neg	Date:	Treatment started: date
MSSA	Pos	Neg	Date:	Treatment started: date

Relevant history for risk assessment. Please give details for positive risk factors.

Recent MI <90 days	Y	N	Date:	Troponin:	
Asthma/COPD/emphysema	Y	N	SaO2 on air:	FEV1:	
			FVC	PEFR:	
Peripheral vascular disease (give details)	Y	N			
History of stroke/TIA (give dates, details of residual deficits, carotid scan results, CT results)	Y	N			
Limited mobility (frailty, neurological problems, etc)	Y	N			
Acute kidney injury (AKI)	Y	N			
CKD 3-4	Y	N			
Dialysis	Y	N			
Diabetic	Y	N	□ Diet	□ Tablet control	□ Insulin
Dental problems	Y	N	Request dental review for valves to avoid delay		
Other significant history	Y	N			