Cardiac CT Request Form

North West Cardiac Imaging Centre

Alliance Medical

Please send your referrals to:

North West Cardiac Imaging Centre, North West Heart Centre, Southmoor Road, Manchester M233 9LT

Tel : 0161 291 4560 Fax : 0161 291 4561

Patient RM2.: _____

NHS No: _____

Surname: _____

Forename: _____

Address: _____

_____

_____ Postcode: _____

D.O.B.: _____ Sex: _____

Tel No: _____

Ward/Dept/Hospital:

Clinic return date:

Referring Consultant:

Previous Echo: _____

Previous CMR: _____

Referring previous coronary angiogram date/nr/findings :

_____

_____

Does any of the below apply	**Yes**	**No**
Is the patient on a beta blocker (BB)?	☐	☐
Any contraindications for BB?	☐	☐
Has the patient asthma, emphysema or significant COPD?	☐	☐
Active congestive heart failure?	☐	☐
High degree AV block?	☐	☐
Is the patient diabetic ?	☐	☐
Is the patient on Metformin?	☐	☐
Could the patient be pregnant?	☐	☐
Is there a cross-infection risk?	☐	☐

Indication for Cardiac CT (please tick as appropriate)

- ☐ Chest pains or SOB of indeterminate cause
- ☐ Equivocal stress test, unable to perform test
- ☐ Chest pains/SOB after CABG / PCI
- ☐ Exclude CAD in low / intermediate / high risk patient
- ☐ (Suspected) congenital HD or anomalies
- ☐ TAVI assessment ☐ Post HTX CAD surveillance
- ☐ Aortopathy
- ☐ Cardiac anatomy (LA, PV, CS, coronary veins)
- ☐ Pre-operative evaluation

Other (please elaborate) _____

_____

Has the patient any renal impairment: Yes ☐ eGFR _____ Creatinine level _____ Date _____

No ☐ If no, please obtain bloods prior to scan appointment.

Advise the patient to omit / stop the following: Cardenafil, Sildenafil (24 hours), Tadalafil, Metformin (48 hours) before and 24 hours after the examination.

Interpreter required? (If yes specific language): _____

Any special needs (e.g. hearing aids / mobility): _____

Further clinical history and specific question to be answered: _____

_____

_____

Is this study requested for ☐ diagnostic purposes or for ☐ risk stratification and prognosis

Referrers Name _____ Referrers Signature _____

Tile/Grade _____ Pager/Bleep/ Tel: _____ Date: _____

Cardiac Imaging Directorate only: Supervised ☐ Unsupervised ☐

Exam code: _____

Coded by: _____

Urgent: ☐ Routine: ☐ Suspend: ☐ Breach date: _____

Clinical indication group: _____

_____

Appropriateness score: _____

_____