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**AORTIC SURVEILLANCE CLINIC REFFERAL**

Date of Referral:

Patient Demographics

Name:

Date of Birth:

Address:

Hospital Number:

Contact Number:

Referring Consultant:

Hospital:

Contact details:

GP details:

Insurance: Public Private

Brief Clinical History and reason for referral:

Does the patient have any known aortic valvular disease? Yes No

Does the patient have any connective tissue disease? Yes No

 If yes, please give details:

Any family history of aneurysm/dissection? Yes No

Any history of previous cardiac surgery? Yes No

Co-morbidities and medication list

Type of Aortic Pathology

 Aneurysm Chronic Dissection Penetrating ulcer/Intramural hematoma

 Other:

Location of Aortic Pathology

 Root Ascending Aorta Arch Descending Thoracic Aorta

Investigations in the last 6 months

 CT scan MRI scan Echocardiogram Other

Most recent imaging (Date and Report):

Most recent echocardiogram (Date and Report):

**Please include the following information with your referral:**

* Patient’s relevant past medical history
* Imaging studies (include CD with images if done outside of St James’s Hospital and not on NIMIS)
* List of current medications
* Recent blood work
* Any other relevant test results

**Note:**

* *This referral form is NOT intended for acute aortic syndromes or clinical emergencies.*
* *It is the responsibility of the referring team to ensure all aspects of the referral are completed. Incomplete forms will be returned and not processed.*
* *Imaging studies should be sent on a CD if not available on St James’s Hospital /NIMIS network*

**Please email the completed form to** **aorta@stjames.ie**

**Imaging CD’s: Mr Saleem Jahangeer – C/O Ciara Byrne SACC – Top floor Hospital 4, St James’s Hospital, Dublin 8**