Referral Form for GSTT Infective Endocarditis MDT

***Please note that full completion of this form, including all contact details, together with electronic transfer of echo images is essential***

***Virtual attendance at our MDT is strongly encouraged***

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| **Patient Name:** |  |
| **NHS Number:** |  |
| **D.O.B./age** |  |
| **Sex:** |  |
| **Date of admission:** |  |
| **Date of referral:** |  |
| **Referring hospital:** |  |
| **Name of referrer:** |  |
| **Name of Consultant looking after patient:** |  |
| **Mobile number of Consultant:**  |  |
| **Email address of Consultant:** |  |

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| **Main question for the GSTT Endocarditis MDT?** |
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| **Prosthetic cardiac devices in situ?** |
| **Prosthetic valve(s)** [ ]  *If prosthetic valve(s), date of implant:***Cardiac implantable electronic device** [ ]  *If CIED, date of implant:* |
| **Other PMH:** |
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| **Clinical case summary:**  |
| **History**:**Signs**:**Admission blood tests**:**Clinical course**: |

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| **Summary of echocardiography findings, including dates and modality (TTE or TOE)** |
| Date(s): | Modality: |
| Date when images transferred to GSTT:  |
| **ECHO Findings**: |

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| **Blood test Results:** |
| Admission WCC: |  | Admission CRP: |  | Admission creatinine: |  |
| Current WCC: |  | Current CRP: |  | Current creatinine: |  |
| **Blood culture results:** |
| **Date(s):** |  |
| **Number of positive bottles:** |  |
| **Name of organism(s):** |  |
| **Full sensitivities:** |  |
| **Cross sectional imaging results (with dates):** |
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| **Details of ALL antibiotics administered during admission, including doses:** |
| **Date antibiotics commenced:** |  |
| **Name of all antibiotics given, including dates and doses:** |  |

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| **Will a member of your team be able to present this patient at our MDT?**  | **Yes/No** |

Please send this completed referral form to the address below:

Gst-tr.endocarditismdt@nhs.net