Cardiac CT Request Form
North West Cardiac Imaging Centre
Please send your referrals to:
North West Cardiac Imaging Centre, North West Heart Centre, Southmoor Road, Manchester M233 9LT
Tel : 0161 291 4560 **e-mail** aml.wythenshawe@nhs.net

District Number: _____ **N HS No:** _____ **Surname:** _____ **Forename:** _____ **Address:** _____ _____ _____ **Postcode:** _____ **D.O.B.:** _____ **Sex:** _____ **Tel No:** _____	**Hospital / Consultant** **Previous cardiac CT / coronary angiogram date/findings :** **Previous cardiac imaging date / findings:**

Indication for Cardiac CT (please tick as appropriate)

- ☐ Coronary artery calcium scoring
- ☐ CT Coronary angiography (with FFRCT (Heartflow) as indicated)
- ☐ CT Coronary angiography (without FFRCT (Heartflow))
- ☐ Graft Study (please provide anatomy if known
- ☐ Aortic valve calcium scoring
- ☐ TAVI assessment (TAVI team only)
- ☐ Cardiac anatomy / structural heart disease assessment

Does the patient have renal impairment?

- ☐ Yes
- ☐ No

eGFR _____ Creatinine _____ Date _____

An eGFR within 3 months is required for booking

Please consider an alternative imaging test in the following scenarios:

- Extreme obesity (BMI > 40kg/m^2)
- Severe asthma / COPD on montelukast, home nebulisers, frequent exacerbations or other malignant history precluding beta-blockade (unless HR < 65bpm)
- Frequent ventricular or atrial ectopy
- Persistent / permanent atrial fibrillation
- Normal CTCA in last 5 years
- Previous PCI | Known CAD (≥50%)
- Inability to control heart rate
- Patient unable to lie flat, hold their breath for up to 15 seconds, or previously unable to tolerate CT scanning
- Renal impairment with eGFR < 30
- Iodine contrast allergy

	Yes	No	Notes
Is the patient on a beta-blocker?			*Please state*
Is the patient on any other rate limiting medications?			*Please state*
Is there a past history of symptomatic bradycardia or AV block?			*Please state*
Clinic heart rate: ……bpm	**n/a**	**n/a**	*If > 65bpm, please consider pre-medication with beta-blocker*
Is the patient taking cardenafil, sildenafil or tadalafil			*Please advise the patient to omit 48 hours prior and 24 hours post scan*
Does the patient have asthma / COPD			*Latest PEFR`*
Is the patient on Metformin?			*This will be discontinued for 48 hours post-scan*
Could the patient be pregnant / breastfeeding?			
Is there an infection risk?			*Please state*

Interpreter required? (If yes specific language): _____

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

Further clinical history and specific question to be answered:

_____

_____

_____

Please consider prescribing beta-blockers to patients referred for CT coronary angiography for suspected coronary artery disease / angina to maximise likelihood of diagnostic images.

Referrer's Name and Grade _____ **Referrer's Signature** _____

Bleep / Tel / NHS email _____ **Date** _____