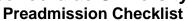
Prof. Eoin O'Malley National Centre for Cardiothoracic Surgery Mater Misericordiae University Hospital



Tel: 01 8032164 Name:	G.P.:		Fax: 01 8034773
Address:			
Referring Hospital MRN	Referri	ng Physician:	
D.O.B:Age:	Referri	ng Hospital:	
Weight	Occupa	ation:	
Scheduled Surgery Details:		Surge	on:
Diagnosis:			
Proposed Surgery Date:		☐ Inpatient	☐ Home (Please tick)
Chest Xray Date:WI	nere done:		_Xray No:
CT Scan Date:	Where done: _		Scan No:
PET Scan Date:	Where done: _		Scan No:
Bronchoscopy: ☐ NO ☐ YES	; Details:		
Histology: ☐ NO ☐ YES; Detail	ls:		
Previous Cardiac/Thoracic Surgery:	□NO	□YE	S Details:
Comorbid Medical Problems			
Respiratory Problems: COAD	\square NO	\square YES	
FEV1K	FVC	L%	
Diabetes: □NO	\square NIDDM	\square IDDM	
Renal Impairment (Creatinine > 115)	□NO	\square YES	
Previous History of Stroke/TIA:	\square NO	□YES	
Angina Pectoris/Previous MI	\square NO	\square YES	
Mobility: \square No Problem	as 🗆 Has	Problems; Ple	ase clarify:
Social: (Please tick appropriate cat Patient lives alone	egory)	□YES	