

East Midlands

Intestinal Failure Service Referral Form

***Please complete all sections of the form.***

***Please note that incomplete forms and attachments will not be assessed by the Intestinal Failure Teams.***

**Please return the form by email to NUHNT.EastMidlandsIFNetwork@nhs.net, writing ‘IF REFERRAL’ in the subject line**

**Date of referral (Admin use only):**

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| --- | --- | --- | --- | --- |
| REASON(S) FOR REFERRAL? *Please mark all boxes that are appropriate* | | | | |
| Please give a brief summary of the reason for referral: | | | | |
| Nutrition team review: | | Surgical Review: | | |
|  | High Output stoma review | Surgical assessment and advice | | |
|  | Parenteral Nutrition Assessment |  | | Surgical reconstruction |
|  | Consideration of Home Parenteral Nutrition |  | |  |
|  | Other – Please give details (If request for advice and guidance only please state): | | | |
| REFERRER INFORMATION | | | | |
| Consultant Name: | | | Hospital Name: | |
| Referrer Email: | | | Secretary Email: | |
| Consultant Contact No: | | | Consultant Email: | |
| Name & contact details of Doctor completing this form: | | | | |
| Please give details of an alternative contact: | | | | |
| **CAPACITY** | | | | |
| Does the patient have capacity to consent? Y / N.  If no: Do they have POA / IMCA / Court Protection / Relative / Friend  *- Please circle as appropriate*  Has Mental Capacity Assessment been undertaken? Y / N *If Yes please attach.*  Does this patient have an active DoLS form? Y / N. | | | | |
| PATIENT INFORMATION | | | | |
| Surname: | | | Title: | |
| First Name(s): | | | Gender: Female  Male  Indeterminate | |
| Home Address: | | | Date of Birth: | |
| Postcode: | |
| Contact Phone Number(s): | | | NHS no: | |
| Patient’s Current Location: | | | | |
| \*Hospital Name: | | | \*Switchboard Number: | |
| \*Ward: | | | \*Direct Tel Number: | |
| Performance Status ECOG: | | | | |
| MEDICAL HISTORY | | | | |
| |  |  |  |  | | --- | --- | --- | --- | |  | Respiratory:  COPD  Asthma  Pulmonary Fibrosis  **Cardiovascular:**  Hypertension  Ischaemic heart disease/ MI  Congestive Cardiac Failure  Arrhythmias/Valvular heart disease  Peripheral vascular disease  DVT/ PE  Gastrointestinal:  Peptic Ulcer Disease  Ulcerative Colitis  Crohn’s  Cirrhosis / Liver Disease |  | Renal:  Acute Kidney Injury  Chronic Kidney Disease  Grade: …………….  Haemodialysis  Neurological:  Stroke / TIA  Dementia  Mitochondrial disorder  Endocrine:  Diabetes Mellitus  Rheumatology:  Scleroderma | | | | | |
| Other: | | | | |

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| INFECTION STATUS & NURSING ISSUES | | | | | | | | | | | | | | | | | | | | | | | | | |
| PLEASE NOTE: A laboratory report confirming the patient’s infection status is a mandatory requirement when referring to this service, and should therefore be attached to this referral when sent. Without this, forms will be deemed incomplete, and returned to you. | | | | | | | | | | | | | | | | | | | | | | | | | |
| Is the patient currently in isolation: Yes / No | | | | | | | | | | | | | | If yes, why: | | | | | | | | | | | |
| MRSA Status: Negative  Positive  Pending | | | | | | | | | | | | | | Date of last MRSA test:  (within last 2 weeks) | | | | | | | | | | | |
| C.diff Status: Negative  Positive  Pending | | | | | | | | | | | | | | Date of last C.diff test: | | | | | | | | | | | |
| Any other relevant cross-infection risks? Yes / No | | | | | | | | | | | | | | Details: | | | | | | | | | | | |
| CURRENT MEDICATIONS *Including anticoagulation, insulin, subcutaneous infusions*  *(Or attach current prescription)* | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Drug** | | | | | | | | | | **Dose** | | | | | | | | | **Route** | | | | | | **Frequency** |
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| ANTICOAGULATION | | | | | | | | | | | | | | | | | | | | | | | | | |
| Anticoagulation? Yes/No | | | | | | \*Prophylactic or therapeutic?  (If therapeutic - please state indication, agreed dose and planned duration below. | | | | | | | | | | | | | | | | | | | |
| Indication: | | | | | | | | | | | | | | | | | | | | | | | | | |
| Agreed dose: | | | | | | | | | | | | | | | | | | | | | | | | | |
| Planned duration: | | | | | | | | | | | | | | | | | | | | | | | | | |
| ALLERGIES and SENSITIVITIES | | | | | | | | | | | | | | | | | | | No known allergies | | | | | | |
| **Medicine or product** | | | | | | | | | | **Reaction** | | | | | | | | | | | | | | | |
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| **Please record if allergic to Egg, Soya, Fish or Nuts:** | | | | | | | | | | | | | | | | | | | | | | | | | |
| SURGICAL SUMMARY | | | | | | | | | | | | | | | | | | | | | | | | | |
| Date | Operation Performed\* | | | | | | | | | | | | | | Indication & Complications | | | | | | | | | | |
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| \*Copies of all operation notes and histology must accompany this referral. | | | | | | | | | | | | | | | | | | | | | | | | | |
| Brief description of current surgical problems: | | | | | | | | | | | | | | | | | | | | | | | | | |
| ANATOMY | | | | | | | | | | | | | | | | | | | | | | | | | |
| Fistulas: | | | | | | | | | | | | Stomas: | | | | | | | | | | | | | |
| |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | | **Estimated length of small bowel in continuity** | | |  | **Is the anus in continuity** | | Choose an item. | | | **Is colonic segment in continuity [C] / defunctioned [D] / resected [R]?** | | | | | | | | | **Ascending** | **Transverse** | **Descending** | | | **Sigmoid** | | **Rectum** | | Choose an item. | Choose an item. | Choose an item. | | | Choose an item. | | Choose an item. | | | | | | | | | | | | | | | | | | | | | | | | | | |
| NUTRITIONAL ASSESSMENT | | | | | | | | | | | | | | | | | | | | | | | | | |
| Current Routes of Nutrition:  *Please mark all routes currently in use* | | | | | | | | | Oral | | | | | | | | | NG | | | | | | Gastrostomy | |
| Parenteral | | | | | | | | | NJ | | | | | | Jejunostomy | |
|  | | | | | | | | | NONE\* | | | | | | | | |  | | | | | |  | |
| \*If no current nutritional route please indicate number of days without nutrition: | | | | | | | | | | | | | | | | | | | | | | | | | |
| Please attach a copy of the current PN prescription to this referral. | | | | | | | | | | | | | | | | | | | | | | | | | |
| Anthropometry: | | |  | | |  | | | | | | |  | | | | | | Date measured: | | | | | |  |
| Weight (Kg): | | |  | | | Weight Loss (Kg): | | | | | | |  | | | | | | Over what duration: | | | | | |  |
| BMI: | | |  | | | Oedema: | | | | | | | Yes | | | | | | No | | | | | |  |
| FLUID BALANCE | | | | | | | | | | | | | | | | | | | | | | | | | |
| Please input the fluid balance for 24 hours and the date of the measurements | | | | | | | | | | | | | | | | | | | | | | Date: | | | |
| Route | | IV | | | Oral | | Other | | | Urine output | | | | | | | NG/Vomit | | | | | Stoma | | | Fistulae |
| Amount/mls | |  | | |  | |  | | |  | | | | | | |  | | | | |  | | |  |
| CURRENT VENOUS ACCESS | | | | | | | | | | | | | | | | | | | | | | | | | |
| If no current line in place, please await Nutrition team review before organising a new feeding line | | | | | | | | | | | | | | | | | | | | | | | | | |
| \*Site:  L  R | | | | IJV | | | | Femoral | | | | | | | | Subclavian | | | | | | |  | | |
| \*Number of lumens: | | | | | | | | | | | | | | | | Date Inserted: | | | | | | | | | |
| Details of Any Thrombosed Veins: | | | | | | | | | | | | | | | | | | | | | | | | | |
| Other conditions not included above/ Notes: | | | | | | | | | | | | | | | | | | | | | | | | | |
| RELEVANT RADIOLOGY (Please attach any imaging reports not available on regional PACS) | | | | | | | | | | | | | | | | | | | | | | | | | |
| Date | | | | Type | | | | | | | | | | | | | | | | Hospital | | | | | |
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| RELEVANT LUMINAL INVESTIGATIONS (Please attach reports and histology) | | | | | | | | | | | | | | | | | | | | | | | | | |
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| LABORATORY INVESTIGATIONS (Can attach print-outs if easier) | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Please ensure that all of the following results are available on referral** | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Hb** | | | | | **Na+** | | | | | | **Albumin** | | | | | | | | | | **ALT** | | | | |
| **WCC** | | | | | **K+** | | | | | | **Corrected Ca2+** | | | | | | | | | | **Bilirubin** | | | | |
| **Platelets** | | | | | **Urea** | | | | | | **PO42-** | | | | | | | | | | **Mg2+** | | | | |
| **INR** | | | | | **Creatinine** | | | | | | **ALP** | | | | | | | | | | **CRP** | | | | |
|  | | | | | **eGFR** | | | | | |  | | | | | | | | | |  | | | | |

**Attachments included?**

**Infection status**

**Operation notes**

**Histology**

**Luminal investigations**

**Radiology**

**What happens after you submit this form?**

* + The referral inbox is checked every weekday by the regional coordinators and referrals are passed on to the appropriate Intestinal failure team (UHL/NUH).
  + The case will then be reviewed by the relevant team member(s) and if needed, will be discussed at the appropriate MDT meeting. – This is dependent on this form being fully completed and all supporting documents being sent with the form.
  + The outcome of the MDT meeting or referral will be communicated to the lead referrer on the day of the meeting.

Please ensure all relevant operation notes and histology results accompany this referral and that you have you all relevant CT/MRI scans are available on the regional PACS.

Please ensure that the patient is aware of the referral to the regional IF service and the fact they might require transfer to either NUH or UHL. Patients will normally be sent to the IF service closest in distance to their home address / hospital. A small number of patients with complex surgical needs may need inpatient assessment at Nottingham even if they live closer to Leicester.