**REFERRAL TO THE SOUTHAMPTON PELVIC MESH REFERAL SERVICE**

|  |  |  |
| --- | --- | --- |
| Patient name: | Preferred tel no: | Email: |
| Address: Postcode: | | |
| Name of patient’s GP: | GP tel no: | |
| GP email address: | GP phone number: | |
| Interpreting services required? Yes  No | Language required: | |
| **Origin of Referral** | | |
| Hampshire  Isle of Wight  Dorset  Out of Area  If out of area, please choose reason:  Treatment option required not available in region  Patient choice  Other (please specify)  *……………………………* | | |
| **Current waiting time** | | |
| RTT clock start date: …………………………….. Current weeks waiting: ………………………… | | |
| **Medical/Surgical History** | | |
| **GP medical history** attached  **BMI** (in past month):  If BMI over 35, please tick box to confirm formal referral to Weight Management Services:  Waist measurement (cm):  Hip measurement (cm):  HBA1C (in past month):  Has the patient seen **local Pain Management Services**? Yes  No   *If yes, please provide details including letters*  Has the patient had **previous input from psychological or psychiatry services**? Yes  No  *If yes, please provide details including letters* | | |
| **Imaging** | | |
| MRI Pelvis  Additional imaging already available | | |
| Please provide details and reports, including **the local MRI report**: | | |
| **Operation Notes** | | |
| Operation notes from original mesh insertion (required) | Operation notes for any additional mesh related procedures (required) | |

**Mesh MDT Referral Form**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Referrer Details** | | | | | | | | | | | | | | | | | |
| **Name of referrer** | | | | | Click here to enter text. | | | | | | | | | | | | |
| **Consultant and specialty** | | | | | Click here to enter text. | | | | | | | | | | | | |
| **Referring hospital** | | | | | Choose an item. | | | | | | | | | | | | |
| **Date of referral** | | | | | Click here to enter a date. | | | | | | | | | | | | |
| **Referrer’s contact details** (phone/fax/email) | | | | | Click here to enter text. | | | | | | | | | | | | |
| **Patient Details** | | | | | | | | | | | | | | | | | |
| **Name** | | | | Click here to enter text. | | | | | | | | | | | | | |
| **DOB** | | | | Click here to enter text. | | | | | | | | | | | | | |
| **NHS number** | | | | Click here to enter text. | | | | | | | | | | | | | |
| **Referring Hospital number** | | | | Click here to enter text. | | | | | | | | | | | | | |
| **Patient presenting complaint:** | | | | Click here to enter text. | | | | | | | | | | | | | |
| **Please indicate purpose of MDT discussion** (tick appropriate box) | | | | | | | | | | | | | | | | | |
| **Patient for discussion only at Mesh MDT** | | | |  | | | **Patient referred to Mesh MDT** | | | |  | **Patient aware of referral** | | | | | Choose an item. |
|  | | | | | | | | | | | | | | | | | |
| **New patient** |  | | **Recurrent Problem** | | | | |  | **MDT update only** | | | |  | | **Other** |  | |
| **Investigations you wish to be reviewed at MDT** | | | | | | | | | | | | | | | | | |
|  | | **Date** | | | | **Investigation performed?** | | | | **Hospital** | | | | **Patient aware of result** | | | |
| **USS** | | Click here to enter a date. | | | | Choose an item. | | | | Choose an item. | | | | Choose an item. | | | |
| **MRI** | | Click here to enter a date. | | | | Choose an item. | | | | Choose an item. | | | | Choose an item. | | | |
| **CT** | | Click here to enter a date. | | | | Choose an item. | | | | Choose an item. | | | | Choose an item. | | | |
| **Cystoscopyyy** | | Click here to enter a date. | | | | Choose an item. | | | | Choose an item. | | | | Choose an item. | | | |
| **Other** | | Click here to enter a date. | | | | Choose an item. | | | | Choose an item. | | | | Choose an item. | | | |
|  | | | | | | | | | | | | | | Choose an item. | | | |
| **MDT Clinical Discussion Details** (please specify any questions to be answered by MDT) | | | | | | | | | | | | | | | | | |
| Click here to enter text. | | | | | | | | | | | | | | | | | |
| **Past surgical history** (in particular, any previous abdominal surgery inc. Caesarean section) | | | | | | | | | Click here to enter text. | | | | | | | | |
| **Comorbidities:** | | | | | | | | | | | | | | | | | |
| Heart disease (e.g. angina, previous MI, valvular disease/AF) | | | | | | | | | Click here to enter text. | | | | | | | | |
| Diabetes (please specify medication) | | | | | | | | | Click here to enter text. | | | | | | | | |
| Respiratory disease (COPD/asthma/PEs etc) | | | | | | | | | Click here to enter text. | | | | | | | | |
| Anticoagulation therapy | | | | | | | | | Click here to enter text. | | | | | | | | |
| Other significant comorbidities | | | | | | | | | Click here to enter text. | | | | | | | | |
| **All sections of the form must be completed for MDT discussion to take place. Incomplete forms will cause delay in discussion and be returned to you.**  **We will only accept email receipt of this form**  **Please email completed form to: uhs.pelvicreferralservice@nhs.net** | | | | | | | | | | | | | | | | | |