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

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| 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**

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| **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** |