**West London Intestinal Rehabilitation Service**

**Severe Intestinal Failure & Home Parenteral Support Referral**

To be completed electronically in full & emailed to nwlh-tr.IFU@nhs.net AND IRSadmin@stgeorges.nhs.uk

Referrals will be triaged and reviewed by both the St Mark’s and St. Georges Intestinal Rehabilitation teams and the referring service notified of the outcome by email

For telephone enquiries call the IF coordinator at St Mark’s (020 8453 2389 or 07970 354630) or St Georges (0208 725 0450)

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| **Referral** |
| **Referral date** |  |

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| **Patient Information** |
| **Title** |  |
| **Patient forename** |  |
| **Patient surname** |  |
| **Date of birth** |  |
| **Gender** |  |
| **Home address with postcode** |  |
| **NHS number** |  |
| **Patient home telephone** |  |
| **Patient mobile** |  |
| **Patient email** |  |

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| **GP Information** |
| **GP name** |  |
| **GP address** |  |
| **GP postcode** |  |
| **GP phone number** |  |

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| **Referring Trust & consultant details** |
| **Referring Consultant** |  |
| **Trust name** |  |
| **Hospital**  |  |
| **Ward** |  |
| **Hospital phone number** |  |
| **Referring consultant’s secretary number** |  |
| **Referring consultant’s email address** |  |
| **Ward phone number** |  |
| **Ward doctors phone/bleep number** |  |
| **MDT contacts** | Dietitian | Phone |  | Email |  |
| Doctor | Phone |  | Email |  |
| Nurse specialist | Phone |  | Email |  |
| Pharmacist | Phone |  | Email |  |

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| **Reason for referral (tick all that apply)****Please state if you would like us to take over surgical care** |
|  | Y/N | Reason |
| Short bowel (high output despite standard care) |  |  |
| EC fistula (high output despite standard care) |  |  |
| Intestinal obstruction  |  |  |
| Intestinal dysmotility |  |  |
| Mucosal disease |  |  |
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| Palliative HPN |  |  |
| Requiring surgical assessment  |  |  |
| Requiring psychiatric/psychological support |  |  |
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| Known HPN patient with HPN complications |  |  |
| Other (describe) |  |  |

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| **Medical information** |
| **Current medical history** Events leading up to the development of IF, with dates |  |
| **Comorbidities**Please give details | Cardiac |  |
| Respiratory |  |
| Renal |  |
| Urological |  |
| Hepatic |  |
| Endocrine |  |
| Haem inc. VTE |  |
| Neurological |  |
| Gynae |  |
| Psych |  |
| Other |  |
| **Pressure sores** |  |
| **Background medical history**Please give as much detail as possible, with dates |  |  |
| **Previous operations**Please list ALL relevant operations and attach operation notes | **Date** | **Operation** |
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| **Intestinal anatomy**Please record areas resected, length of each part of remaining SB and location of any strictures or areas of known disease eg Crohn’sA drawing can be achieved by using the markers on the [Draw] tab |  |
| **Site and no. of any stomas/fistulae/enteral tubes/drains etc**A diagram is often best A drawing can be achieved by using the markers on the [Draw] tab |  |
| **Enterocutaneous fistula(e) and anatomy** | Fistula from small bowel / colon |  |
| Involving other organs (eg bladder, vagina) |  |
| Distance from DJ flexure (if known) |  |
| Laparostomy wound? |  |
| Persistent intra-abdominal sepsis or collections? |  |
| Fistula output (ml/24h) |  |
| **Recent imaging reports** CTs/MRIs/USSBarium/Venograms*Once referral accepted please IEP the imaging for this patient* |  |

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| **Current medications** | Name | Dose | Frequency | Route |
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| **Allergies** |  |

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| **Current routes of nutrition & fluids**(if not currently being used please state whether previously trialled, and reason for discontinuing**)** | Oral |  |
| NG |  |
| NJ |  |
| Gastrostomy  |  |
| Jejunostomy |  |
| Distal enteral feeding (enteroclysis/fistuloclysis) |  |
| Parenteral nutrition (please attach PN prescription) |  |
| Additional IV fluids & electrolytes | Yes/No     (If yes, daily or weekly average) |  |

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| **Venous access**Give details of all venous access devices that the patient has | Type of catheter used for PN and/or IV fluids & electrolytes?  |  |
| Date of insertion |  |
| Any central veins thrombosed? |  |
| CVC sepsis history |  |

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| **Patients with extensive malignancy for palliative HPN** | Oncology treatment plan  |  |
| Palliative care input & plan (hosp & community)including withdrawal of PN support |  |
| DNAR details |  |
| End of life discussions been initiated with the patient? (please expand) |  |
| Karnofsky performance status (0-100)  |  |
| CRP |  |
| Albumin |  |
| Estimated prognosis |  |

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| **Nutrition assessment****(please specify date)** | Weight (kg) |  |
| Height (m) |  |
| BMI |  |
| Recent weight loss? (over how long) |  |
| Oedema? |  |
| MUAC (cm) |  |
| Handgrip strength (kg) |  |

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| **Mobility** | Bed bound |  |
| Mobilising with aid |  |
| Mobilising independently |  |

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| **Social information** | Does patient live alone?(If no please give details) |  |
| Discharge destination |  |
| District nurse details (if applicable) |  |
| Package of care details(if applicable) |  |

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| **Please ensure that the patient is aware:** | **They will undergo a period of assessment which may be for 6-8 weeks or more** |
| **Any surgery will not be performed on their initial admission** |

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| **PLEASE NOTE** | **If following a period of stay at St Mark’s or St George’s, this patient is unable for any medical or social reasons to return home or to a suitable placement then we formally agree to readmit this patient back to this hospital** |

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| **Patient consent** | The clinician responsible for the patient confirms that they have discussed this referral with the patient (or in the case of a minor the parent/legal guardian/carer and in the case of an adult without capacity followed the process as set out by the MCA 2005). They have given appropriate explicit consent for sensitive personal information to be passed to the West London Intestinal Rehabilitation Service for processing this request | Yes/No |

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| Form completed by |  | Grade |  |
|  |
| Date |  |
| Name |  |
| Signature |  |
| Phone Number |  |
| Email |  |