**REFERRAL TO THE SOUTHAMPTON SPECIALISED MESH COMPLICATIONS 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.** |