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**CAMBRIDGE CENTRE FOR INTESTINAL REHABILITATION REFERRAL FORM**

**All inpatient referrals require a Consultant to Consultant telephone discussion prior to acceptance**

**Please contact the Ward Intestinal Rehabilitation Consultant via switchboard on 01223 805000 – then complete the date of discussion and accepting CUH Consultant on the form**

Please ensure this form is completed in full and emailed to add-tr.PNteam@nhs.net.

**The patient will be placed on the waiting list for transfer on receipt of the fully completed form**

Please contact the Intestinal Rehabilitation Co-ordinator on 01223 216037 (option 3) or the above email address

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| **Date of Referral:** Click or tap to enter a date. |

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| **Patient Information** | **Next of Kin Contact Details** |
| **TITLE:****PATIENT FORENAME:** **PATIENT SURNAME:****NHS NO:** **DATE OF BIRTH:** **ADDRESS (including postcode):****CONTACT NUMBER: HOME** **MOBILE** **EMAIL ADDRESS:****GENDER:** | **NAME:****RELATIONSHIP:****CONTACT NUMBER: HOME** **MOBILE**  |
| **GP Details** |
| **GP NAME & ADDRESS (including postcode):****GP TELEPHONE NUMBER:** |

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| **Referring Hospital & Consultant Details** |
| **REFFERRING CONSULTANT:** | **REFERRING HOSPITAL:** |
| **REFERRING CONSULTANT CONTACT NUMBER:** | **HOSPITAL CONTACT DETAILS: (include extension/bleep)****Ward:****Dietitian:****Nutrition Nurse:** |
| **REFERRING CONSULTANT E-MAIL:** | **DATE ADMITTED TO REFERRING HOSPITAL:** |
| **SPECIALITY:** | **CURRENT PATIENT LOCATION:** |
| **FORM COMPLETED BY:****NAME:****BLEEP:** | **GRADE:****EMAIL:** |

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| **DETAILS OF CONVERSATION WITH / AND NAME OF CUH CONSULTANT ACCEPTING REFERRAL:** Date of ConversationAccepting Consultant [ ]  Dr Charlotte Rutter [ ]  Dr Dunecan Massey [ ]  Dr Jeremy Woodward |
| **REASON FOR REFERRAL:** (More than 1 box can be checked)[ ] Nutrition Assessment [ ]  HPN/HIVF set-up [ ] Palliative PN set-up [ ] Surgical assessment |

**By completing this form, I confirm that if, following a period of assessment and/or treatment at the Cambridge Centre for Intestinal Rehabilitation, this patient is unable to return home or be discharged to a suitable placement for any medical/social reasons, I agree to transfer him/her back to the referring hospital under my care.**

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| **Transfer Information** |
| When a bed becomes available our bed managers will contact you to arrange transfer. At the time of transfer it is essential that the following documentation is sent with the patient. 1. Copies of relevant patient medical notes
2. Drug chart
3. PN and/or EN script, if applicable

In the meantime should any advice be required please contact us. If the patient no longer needs transfer please inform the IF co-ordinator.Please ensure the patient is aware they will undergo a period of assessment and an inpatient stay of a minimum of 2- 4 weeks before being discharged home. Any further surgery **is unlikely to** be performed during this initial admission. |
| **Medical History** |
| **UNDERLYING DIAGNOSIS, DESCRIPTION OF EVENTS, SURGICAL PROCEDURES:**Please send copies of operation notes, pathology reports and endoscopic investigations where possible |
| **PAST MEDICAL HISTORY:**Please send relevant results/reports e.g. echocardiogram, lung function tests, radiological investigations  |
| **PRESUMED ANATOMY:** Descriptive text, including location of strictures or areas of known disease eg. Crohn’s disease:Small bowel length proximal: cm distal: cm [ ] Don’t knowColon length in situ: cm In continuity?: [ ] Yes [ ]  No |
| **STOMA CARE:** [ ] Stoma (pls specify number and type) [ ]  Fistula [ ]  Laparostomy [ ]  N/A |
| **SOCIAL HISTORY:****CURRENT MOBILITY:** Choose an item. **AID:****PROPOSED DISCHARGE DESTINATION:** **FAMILY AVAILABLE TO SUPPORT PATIENT?:** [ ] Yes [ ]  No**BARRIERS TO DISCHARGE EG. REHABILITATION/HOUSING:** |
| **CAPACITY:** (Please select one option relating to making decisions about artificial feeding)[ ] Has mental capacity [ ] Lacks mental capacity DATE ASSESSED: Click or tap to enter a date. BY WHOM: |

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| **Current Medications** |
| **Drug** | **Dose** | **Route** | **Frequency** |
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|  **ALLERGIES:** [ ]  No [ ] Yes (please specify) |
| **Nutrition** |
| **CURRENT NUTRITIONAL STATUS:****DATE MEASURED:** Click or tap to enter a date. **WEIGHT(CURRENT): kg****OEDEMA?** [ ] YES [ ] NO **ESTIMATED DRY WEIGHT: kg****HEIGHT: BMI:****WEIGHT ON ADMISSION: WEIGHT LOSS: % OVER: WEEKS/MONTHS** |
| **CURRENT NUTRITIONAL REQUIREMENTS:****ENERGY: NITROGEN:** |
| **CURRENT ROUTE(S) OF NUTRITION:** *(If enteral nutrition please ensure feed regime is included)*[ ]  **ORAL**[ ]  **NG / PEG** TUBE DETAILS:[ ]  **NJ / JEJUNOSTOMY** TUBE DETAILS:[ ]  **PARENTERAL** PN START DATE:**ENTERAL FEED REGIME + START DATE:** |
| **PN DETAILS:** (Please email current PN prescription at time of submitting referral form with most recent blood results)**AQUEOUS/ LIPID BAGS: DAYS PER WEEK: VOLUME (mls):** **RATE AND INFUSION LENGTH (mls/hr): TOTAL ENERGY (kcal) :** **NITROGEN(g): Na (mmol): K (mmol):** **Ca (mmol): Mg (mmol): Phos (moll):**  |
| **CURRENT OUTPUT VOLUME (mls):** [ ]  **FROM SB** [ ]  **FROM COLON** [ ]  **OTHER**  |

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| **Venous Access** (Please liaise with your Nutrition Nurse Specialist) |
| **VENOUS ACCESS: DATE INSERTED: Click or tap to enter a date.****Tunnelled CVC** [ ]  YES [ ]  NO **Cuffed** [ ]  YES [ ]  NO[ ]  **PORTOCATH** [ ] **PICC External Length:****NUMBER OF LUMENS:** [ ] 1 [ ] 2 [ ] 3 [ ] 4 [ ] 5 **SITE:** [ ] Right [ ] Left [ ] IJV [ ] SCV [ ] Fem **ARE ANY VEINS THROMBOSED?**  [ ] NO [ ] YES**DETAIL:**  |
| **LINE HISTORY:** (Please include information on previous lines, microbiology results and reason for removal) |

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| **Blood Results** |
| Date Measured: | Click or tap to enter a date. |
| **HB** | **Na+** | **Bili** | **Ca2+** | **ESR** |
| **MCV** | **K+** | **ALT** | **PO42+** | **Ferritin** |
| **WCC** | **Ur** | **ALP** | **Mg2+** | **B12** |
| **PLT** | **CR** | **ALB** | **CRP** | **Folate** |

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| **Infection Prevention** |
| VRE: ESBL: CRE: MRSA: C.diff: Other Last COVID-19 PCR: Date: |

**FOR PALLIATIVE HOME PARENTERAL NUTRITION (PN) PATIENTS ONLY**

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| **ECOG SCORE:** | Choose an item. |
| **FLUID BALANCE:****(ml- Last 24 hours)** |

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| **IN**  | **ORAL:** | **NG:** | **IV:** | **PN:** | **OTHER:** |  |  |  |
| **OUT** | **URINE:** | **STOOL:** | **NG:** | **VOMIT:** | **PEG:** | **STOMA:** | **FISTULA:** | **OTHER:** |
| **TOTAL BALANCE** |  |

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| **ADVANCE CARE PLANNING****And****PREFERRED PRIORITIES FOR CARE**(Patients for palliative PN MUST have Specialist Palliative Care Services involved) | **DISCUSSED WITH PATIENT:** By Whom?:**DISCUSSED WITH FAMILY:** By Whom?:**SEEN BY PALLIATIVE CARE IN HOSPITAL:** YES/NO. **SEEN BY PALLIATIVE CARE IN COMMUNITY:** YES/NO. **NAME OF COMMUNITY TEAM:****PATIENT’S WISHES & PRIORITIES:****FAMILY’S WISHES & PRIORITIES:****PLANS FOR WITHDRAWING NUTRITION DISCUSSED WITH WHO:** |
| **LIST OF RESPONSIBLE PERSONS AND CONTACT DETAILS** | * **RESPONSIBLE CONSULTANT**

|  |  |
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| Name |  |
| Email | Phone |

* **GASTRO CONSULTANT**

|  |  |
| --- | --- |
| Name |  |
| Email | Phone |

* **PALLIATIVE CARE CONSUTLANT & SPECIALIST NURSE IN HOSPITAL AND IN COMMUNITY**

|  |  |
| --- | --- |
| Name |  |
| Email | Phone |

* **CONSULTANT RESPONSIBLE ON DISCHARGE/IN COMMUNITY**

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| Name |  |
| Email | Phone |

* **GP, DISTRICT NURSE & COMMUNITY NUTRITION TEAM CONTACTS**

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| Name |  |
| Email | Phone |

* **OTHERS**

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| --- | --- |
| Name |  |
| Email | Phone |

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