# Intestinal Failure Referral Form

**This form must be completed in full and emailed to UCLH.IFReferrals@nhs.net or call 07958 263178.**

***Please complete all sections of the form.***
***Please note that incomplete forms will not be assessed by the Intestinal Failure Team.***

**What are you referring the patient for? (Delete as appropriate)**

Surgical ECF Repair Yes/No

Home Parenteral Nutrition Yes/No

**Other (Please state)……**

| **PATIENT INFORMATION** | |
|---|---|
| **Surname:** | **Title:** |
| **First Name/s:** | **Gender:** Female ☐ Male ☐ |
| **Home Address:** | **Date of Birth:** |
| | **Postcode:** |
| **Contact Phone Number/s:** | **NHS no:** |
| **GP Name:** | **GP Postcode:** |
| **GP Address:** | |
| **Patient's Current Location:** | |
| ***Hospital Name:** | ***Switchboard Number:** |
| ***Ward:** | ***Direct Tel Number:** |
| **Side Room: Yes / No** | **If yes, why?** |

## INFECTION STATUS & NURSING ISSUES

**PLEASE NOTE:** A laboratory report confirming the patient's infection status is a mandatory requirement when referring to this service, and should therefore be attached to this referral when sent. Without this, forms will be deemed incomplete, and returned to you.

| | |
|---|---|
| **Is the patient currently in isolation: Yes / No** | **If yes, why:** |
| **MRSA Status:** Negative ☐ Positive ☐ Pending ☐ | **Date of last MRSA test:** **(within last 2 weeks)** |
| **C.diff Status:** Negative ☐ Positive ☐ Pending ☐ | **Date of last C.diff test:** |
| **Carbapenemase-producing Organism: Yes / No** | **Date of last positive test:** **Site:** |
| **Carbapenem-resistant Enterobactericaceae: Yes / No** | **Date of last positive test:** **Site:** |
| **Is the patient positive for any infection: Yes / No** | **List:** |
| **Pressure Areas Intact:** Yes ☐ No* ☐ ***Details:** | **Mobility:** |

## REFERRER INFORMATION

| | |
|---|---|
| **Consultant Name:** | **Hospital Name:** |
| **Referrer Email:** | **Ward Name:** |
| **Referrer's Bleep:** | **Name & contact details of person completing this form:** |

## SURGICAL SUMMARY

| Date | Operation Performed* | Surgeon | Indication & Complications (inc. ITU admissions**) |
|---|---|---|---|
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*** All operation notes must be e-mailed to us as part of the referral process**
**** Any ITU discharge summaries must be e-mailed to us as part of the referral process**

**Brief Description of Surgical Problems:**

## NUTRITIONAL ASSESSMENT

**Current Routes of Nutrition:** Oral ☐ NG ☐ NJ ☐ Parenteral ☐ Gastronomy ☐ Jejunostomy ☐

**Current Artificial Nutrition Prescription** (with the aid of your ward Dietician):

Formula Name:

Volume /24hr: Calories: Nitrogen: Glucose: Lipid:

$Na^{+}$: $Mg^{2+}$:

**Anthropometry:**
Date measured: Weight (Kg):
BMI: Weight Loss (Kg):
Over what duration: Oedema: Yes ☐ No ☐

**ECF Daily Output (ml) (over last 7 days):**

## VENOUS ACCESS

(Please liaise with your Nutrition Nurse Specialist)
**Form(s) of IV access:** None ☐ CVC Tunnelled* ☐ Implanted Port ☐ PICC ☐

**For CVCs - *Number of lumens:** ***Site:** R ☐ L ☐ IJV ☐ Femoral ☐ Subclavian ☐
***Date Inserted:** ***Any Thrombosed Veins?** Yes ☐ No ☐

## MEDICAL HISTORY

**Respiratory:**
COPD ☐
Asthma ☐
Lung Cancer/ Mesothelioma ☐
Pulmonary Fibrosis ☐

**GastroIntestinal:**
Oesophagitis/ GORD ☐
Peptic Ulcer Disease ☐
Hiatus Hernia ☐
Liver Cirrhosis/ Hep B/ C ☐
Inflammatory Bowel Disease ☐

**Cardiovascular:**
Hypertension ☐
Ischaemic heart disease/ MI ☐
Congestive Cardiac Failure ☐
Arrythmias/ Valvular heart disease ☐
Peripheral vascular disease ☐
DVT/ PE ☐

**Renal:**
Acute renal Failure ☐
Chronic Renal Failure ☐
Haemodialysis ☐

**Neurological:**
CVA/ TIA ☐
Dementia ☐
Neuropathy ☐

**Endocrine:**
Diabetes Mellitus ☐
Thyroid Disease ☐

**Other conditions not included above/ Notes:**

## CURRENT MEDICATIONS

*Including anticoagulation, insulin, subcutaneous infusions*

| Drug | Dose | Route | Frequency |
|---|---|---|---|
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**ALLERGIES:**

No known drug allergies ☐

| Drug | Reaction |
|---|---|
| | |
| | |

**Laboratory Investigations**

| | | | |
|---|---|---|---|
| **Hb** | **$Na^+$** | **ALP** | **$Mg^{2+}$** |
| **WCC** | **$K^+$** | **ALT** | **Corrected $Ca^{2+}$** |
| **Platelets** | **Urea** | **AST** | **$PO_4^{2-}$** |
| **INR** | **Creatinine** | **GGT** | **CRP** |
| **APTTR** | **eGFR** | **Bilirubin** | |
| **Fibrinogen** | | **Albumin** | |

**What happens after you submit this form?**

- The case will be discussed at the Intestinal Failure MDT meeting (held every Friday) within 2 weeks of receiving the referral form – this is dependent on this form being fully completed and all supporting documents being sent with the form.
- The outcome of the MDT meeting will be communicated to the lead referrer on the day of the meeting.

**Pre-submission checklist:**

☐ Is the referral form completed as comprehensively as possible to minimise delays?

- ✓ Contact details for inpatient teams are vital to ensure clear lines of communication.

☐ Have you linked all relevant CT/ MRI scans to UCH on the IEP?

☐ Have you scanned and e-mailed all relevant supporting documents?

- ✓ Outpatient clinic/referral letters.
- ✓ Operation notes.
- ✓ Radiology reports.
- ✓ Histology reports.
- ✓ TPN/ Enteral feed prescription chart.
- ✓ Intensive Care admission summaries – if applicable.
- ✓ ECG/echocardiogram/CPEX reports – please look at patient's medical history to decide if these are warranted.