NHS
Central London
Intestinal Failure Partnership

Intestinal Failure Referral Form

This form must be completed in full and emailed to uclh.referrals.clip@nhs.net

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

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 attached a full picture of the patient's abdomen? • 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. • Laboratory reports. • 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.

What happens after you submit this form?
• The case will be discussed at the Intestinal Failure MDT meeting (held every Tuesday) 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.

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Reason for referral? (more than one box can be ticked)

IF surgery ☐ Home parenteral nutrition ☐ Transition from paediatric IF service ☐

Date of referral

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

REFERRER INFORMATION	
Consultant Name:	**Referrer's Bleep/Mobile Number:**
Referrer's Name:	**Referrer's e-mail address:**

MEDICAL HISTORY	
Neurological: CVA/TIA ☐ Dementia Neuropathy ☐	**Endocrine:** Diabetes mellitus ☐ Thyroid disease ☐

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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 ☐
Respiratory: COPD ☐ Asthma ☐ Lung cancer/Mesothelioma ☐ Pulmonary Fibrosis ☐	**Gastrointestinal:** Oesophagitis/GORD ☐ Peptic ulcer disease ☐ Hiatus hernia ☐ Liver cirrhosis ☐ Hepatitis B ☐ Hepatitis C ☐ Inflammatory Bowel Disease ☐
Other conditions not included above/notes:	
Performance status:	**Predicted life expectancy >3 months?** Yes ☐ No ☐

CURRENT MEDICATIONS (can attach a screenshot of drug chart)

Including anticoagulation, insulin, subcutaneous infusions

Drug	Dose	Route	Frequency

ALLERGIES:

Drug	Reaction

SURGICAL SUMMARY

Date	Operation Performed*	Surgeon	Indication & Complications (inc. ITU admissions**)

*** 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**

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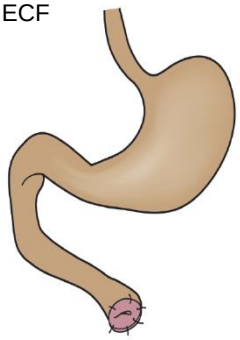
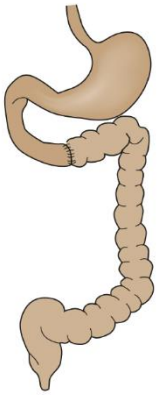
Brief Description of Current Problems:

Anatomical IF classification

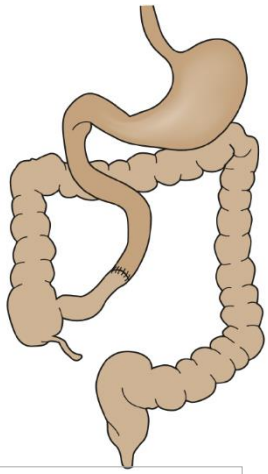
Please addend with additional information as needed eg ECF



Type I
Jejunostomy



Type II
Jejunocolonic anastomosis



Type III
Ileocolonic anastomosis

Fistula (entero-cutaneous or other)

Colon ☐ **SB** ☐ **Other** **Output (7-day average):** mls/24hrs

Bowel length
Proximal: cm Distal: **c**m Don't know ☐

Laparostomy wound ☐ **Gastrostomy tube** ☐ **Persistent intra-abdominal sepsis** ☐

BLOODS

Latest Laboratory Investigation (ideally attach a screenshot of the last 7-days)			
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**	

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NUTRITIONAL ASSESSMENT (To be completed by Dietitian)

Current Routes of Nutrition: Oral ☐ NG ☐ NJ ☐ Gastrostomy ☐ Jejunostomy ☐ Parenteral ☐
(Tick all in use)

Dietary information (to be completed by a dietitian)

Patient NBM: Yes ☐ No ☐

Estimated oral intake (if applicable):

Does the patient have any dietary restrictions (if applicable):

Estimated enteral feeding intake (if applicable):

If failed enteral feeding, why (including feeding regimens provided)?

If has a feeding tube in situ, what is the size and make of the tube (inc date of insertion)?

Current Artificial Nutrition Prescription: (please attach the last 7 days prescriptions)
Date started PN:

Has the patient been receiving any IV fluids +/- IV electrolytes? Yes ☐ No ☐
If so, please provide a summary of the previous 7 days prescriptions

Anthropometry:
Date measured: Weight (kg): Height (cm):

BMI: kg/m^2 Oedema: Yes ☐ No ☐

Previous weights (kg) (inc. dates):

% weight change in previous 3-6 months

MUAC/ Handgrip strength: Dominance Right Hand ☐ Left Hand ☐

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To be completed by Nutrition Nurse or NIC

VENOUS ACCESS

Form(s) of IV access: None ☐ CVC: Temporary ☐ Tunnelled ☐ Implanted Port ☐ PICC ☐
For CVCs Number of lumens: **Site:** R ☐ L ☐ IJ ☐ Femoral ☐ Subclavian ☐
Date Inserted: **Any Thrombosed Veins?** Yes ☐ No ☐ Details:

NURSING ISSUES

Is the patient or family able to be trained administer PN or IV fluids independently? Yes ☐ No ☐	**If yes who will it be?**

Pressure Areas Intact: Yes ☐ No ☐ **Details:**

INFECTION STATUS

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:**
Last covid19 test date, type of test, and result:	

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MOBILITY
Bed bound: Yes ☐ No ☐ **Transfer details:**
Mobilising with aid: Yes ☐ No ☐ **Details:**
Mobilising independently: Yes ☐ No ☐ **Details:**
SOCIAL INFORMATION
Living situation? Alone ☐ With family ☐ Other
Discharge destination:
Package of care details (if applicable):