|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| To be completed by Referring Consultant / Secretary and emailed to Private Patient Admissions  [privatepatientadmissions@cromwellhospital.com](mailto:privatepatientadmissions@cromwellhospital.com)  *Please note that the Cromwell Hospital will endeavour to respond with a local agreement within 24 hours, however this request will require approval from NHS England and may take a further 48 hours to respond with a final confirmation. To speak to a member of staff about the approval status of your request please contact the Helpline on* ***+44 (0)20 7460 5701*** | | | | | | | | | | | | | | | | | | |
| **PATIENT DETAILS** | | | | | | | | | | | | | | | | | | |
| **Title:** | | | **Surname:** | | | | | | | | | | **First Name(s):** | | | | | |
|  | | |  | | | | | | | | | |  | | | | | |
| **Patient Correspondence**  **Address:** | | | | | | | | **DoB:** | | | | | | **Age:** | | | | |
|  | | | | | | | | **GP name and address:**  **GP Phone:** | | | | | | | | | | |
| **Patient Phone:** | | | | | | | | **Confirm GP has been informed YES NO** | | | | | | | | | | |
| **Patient Mobile:** | | | | | | | | **MRN:**  Patient ***has not*** visited Cromwell before. Need new MRN  Patient ***has*** visited Cromwell before, butunsure of MRN | | | | | | | | | | |
| **Patient Email:** | | | | | | | |
| **Payer:** | | | | | | | | **Membership / Policy Number:** | | | | | | | | | | |
| **Referring Consultant Details** | | | | | | | | | | | | | | | | | | |
| Referring Consultant Name: | | | | | | | | | | | | | | | | | | |
| **Contact details:** | | | | | | | | | | | | | | | | | | |
| **CLINICAL DETAILS** | | | | | | | | | | | | | | | | | | |
| **Current clinical condition**  **Radiological results**  **Histopathology results**  **Which MDT should this patient be discussed at?**  **GP Letter attached: Yes / No** | | | | | | | | | | | | | | | | | | |
| **Planned proposed procedure / treatment:**  **Justification for procedure / treatment:**  **Have all alternative treatment options been explored? If so, what?**  **Please state if treatment has already been undertaken [level 1a/1b]:** | | | | | | | | | | | | | | | | | | |
| **ASSESSMENT OF SURGICAL PRIORITY / or NCEPOD CLASSIFICATION [tick]** | | | | | | | | | | | | | | | | | | |
| **Priority level 1a emergency operation needed within 24 hours / immediate** | | | | | | | | | | | | | | | |  | | |
| **Priority level 1b urgent operation needed within 72 hours / urgent-expedited** | | | | | | | | | | | | | | | |  | | |
| **Priority level 2 Surgery that can be deferred for up to 4 weeks / semi-acute** | | | | | | | | | | | | | | | |  | | |
| **Priority level 3 Surgery that can be delayed for up to 3 months** | | | | | | | | | | | | | | | | **n/a** | | |
| **Priority level 4 Surgery that can be delayed for more than 3 months** | | | | | | | | | | | | | | | | **n/a** | | |
| **ADMISSION DETAILS** | | | | | | | | | | | | | | | | | | |
| **Preferred days or week of Admission** (please note this is subject to Theatre availability)**:** | | | | | | | | | | | | | | **LoS** (nights)**:**  00ICU / HDU  00 Ward Day case only | | | | |
|  | | | | | |  | | | | | | | |  | | | | |
| **Admitting Consultant:** | | | | | | **CCSD Code:** | | | | | | | | **Diagnosis:** | | | | |
| **Allergies:** | | | | | | **Fasting instructions:** | | | | | | | | **Pregnancy:**  Over 16 wks? | | | | |
| **Please note pre-assessment will take place 48 hours prior to admission, which will include a Covid-19 swab. Please indicate if you require further tests at pre-assessment.** | | | | | | | | | | | | | | | | | | |
| **Tests on Admission** | FBC | U&E’s | | ECG | | LFT’s | CXR | | | | G&S | HB / MSU | | | Clotting Screen | | Admission Profile | XMatch Units |
|  |  | |  | |  |  | | | |  |  | | |  | |  |  |
| **Other Tests:** | | | | | | | | | | | | | | | | | | |
| **Other Patient Information:** | | | | | | | | | | | | | | | | | | |
| **THEATRE DETAILS** | | | | | | | | | | | | | | | | | | |
| **Theatre Booking**  Date:  Time: | | | | | **MRSA Screen:**  Date:  Status: | | | | | | | **Surgical Assistant:** (Yes **/ No)-** | | | | | | |
|
| Anaesthetist: | | | | | **Anaesthesia Type:**  **GA / LA / Sedation** | | | | | | | Xray in theatre: (Yes / No) | | | | | | |
| **Equipment / prosthesis:** | | | | | | | | | | | | | | | | | | |
| **IF A CANCER CASE, PLEASE COMPLETE THE FOLLOWING** | | | | | | | | | | | | | | | | | | |
| **Tumour Group:**  **Urgent Cancer Referral Type:** | | | | | | | | | **Primary Diagnosis Date:**  **Tumour Laterality:**  **Primary Diagnosis ICD10:** | | | | | | | | | |
| **MDT Date:**  **MDT Outcome:**  **Recommended Treatment (surgery, radiotherapy, etc):**  **Referral Checklist** (where available, send results with referral):   * Imaging * MDT Outcome * Pre-assessment results * First stage consent for treatment | | | | | | | | | | | | | | | | | | |
| **HOSPITAL BOOKING OFFICE USE ONLY** | | | | | | | | | | | | | | | | | | |
| Booked in by: | | | | | | | | | | Booked Date: | | | | | | | | |