|  |
| --- |
| To be completed by Referring Consultant / Secretary and emailed to Private Patient Admissionsprivatepatientadmissions@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:  |