Central Manchester University Hospitals NHS
NHS Foundation Trust

University Hospital of South Manchester NHS
NHS Foundation Trust

Greater Manchester Rapid Access Anaphylaxis Clinic (GMRAAC)

REFERRAL FORM

Fax form to 0161 291 5351 between 9:00 and 12:00 Monday to Friday and call 0161 291 5444 to confirm receipt

Please ensure that suitable patient contact details are available (e.g. reliable telephone number) so that the date and time of the appointment can be communicated effectively.

Please ensure all fields are completed.
Please fax a copy of the paramedic sheet, ED and/or other relevant medical notes.

PATIENT DEMOGRAPHICS			
Surname		Forename	
NHS No.		Date of Birth	DD/MM/YY
Address		Telephone	
Referring Consultant and Trust		GP Name GP Surgery	

CLINICAL REFERRAL / INFORMATION			TICK	
Date of presentation	DD/MM/YY	Cutaneous (rash / urticaria)		MILD
Date of discharge	DD/MM/YY	Angioedema (not laryngeal)		MILD
Date of referral	DD/MM/YY	GI upset		MILD
Time of onset	HH:MM	Tachycardia (>120bpm)		MODERATE / SEVERE
Time of initial tryptase	HH:MM	Hypotension		MODERATE / SEVERE
Time of 1-2 hour tryptase	HH:MM	Cardiac arrest		MODERATE / SEVERE
Suspected trigger	Please write here	Wheeze		MODERATE / SEVERE
		Stridor / airway compromise		MODERATE / SEVERE
Preceding circumstances / other information	Please write here			

Patients are only suitable for referral if their presenting features are <u>moderate / severe</u>. If only mild features are present, please ask the patient's GP to consider referral to their local allergy service.

Referring Dr		GMC No.	
Contact no.		Signature	