**Manchester Mesh Service Referral Form**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | | | | | | | | | | |
| **Name of referrer** | | | Click here to enter text. | | | | | | | |
| **Specialty** | | | Click here to enter text. | | | | | | | |
| **Referring hospital** | | | Other (please specify) Click here to enter text. | | | | | | | |
| **If out of area, please choose reason:** | | | Treatment option required not available in region  Patient choice  Other (please specify)  Click here to enter text. | | | | | | | |
| **Hospital mesh procedure performed in** | | | Other (please specify) Click here to enter text. | | | | | | | |
| **Date of referral** | | | Click here to enter a date. | | | | | | | |
| **Referrer’s contact details (phone/fax/email)** | | | Click here to enter text. | | | | | | | |
| **Patient Details** | | | | | | | | | | |
| **Name** | | Click here to enter text. | | | | | | | | |
| **DOB** | | Click here to enter text. | | | | | | | | |
| **NHS number** | | Click here to enter text. | | | | | | | | |
| **Address** | | Click here to enter text. | | | | | | | | |
| **Mesh Type** | | Retropubic  Transobturator  Single incision sling  Vaginal prolapse mesh or kit  Sacrocolpopexy  Sacrohysteropexy  Other (please specify) Click here to enter text. | | | | | | | | |
| **Patient presenting complaint:** | | Click here to enter text. | | | | | | | | |
| **Please indicate purpose of referral** (tick appropriate box) | | | | | | | | | | |
| **MDT discussion only** | |  | | | **Referral to Mesh Service** |  | | **Patient aware of referral** | Choose an item. | |
| **MDT Clinical Discussion Details** (please specify any questions to be answered by MDT) | | | | | | | | | | |
| Click here to enter text. | | | | | | | | | | |
| **Past surgical history** (in particular, any previous abdominal surgery) | | | | | | | Click here to enter text. | | | |
| Has the patient seen **local Pain Management Services**? | | | | | | | Yes  No   *If yes, please provide details including letters* | | | |
| Has the patient had **previous input from psychological services**? | | | | | | | Yes  No  *If yes, please provide details including letters* | | | |
| **BMI** | | | | | | |  | | | |
| **Operation Notes** | | | | | | | | | | |
| Operation notes from original mesh insertion  *Please attach copy* | | | | | | | Operation notes for any other mesh related procedures  *Please attach copies of operation notes and correspondence* | | | |
| **Investigations available for review by MDT** | | | | | | | | | | |
|  | **Investigation performed?** | | | **Date** | | | **Hospital** | | |
| **MRI** |  | | | Click here to enter a date. | | | Other (please specify) Click here to enter text. | | |
| **CT** |  | | | Click here to enter a date. | | | Other (please specify) Click here to enter text. | | |
|  |  | | |  | | |  | | |
| **Cystoscopy** |  | | | Click here to enter a date. | | | Images provided Choose an item.  Other (please specify) *……………………………….* | | |
| **Urodynamics** |  | | | Click here to enter a date. | | | Trace provided. . Choose an item. | | |
| **Other** |  | | | Click here to enter a date. | | | Results provided. Choose an item. | | |
| **(specify)** Click here to enter text. | | | | | | |  | | | |
|  | | | | | | | | | | |
| **We will only accept email receipt of this form to** [mft.mesh@nhs.net](mailto:mft.mesh@nhs.net) | | | | | | | | | | |