**Manchester Mesh Service Referral Form**

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|  |
| **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 |