Bristol Mesh Complications Specialist Service Referral Form

# Referrer Details

|  |  |
| --- | --- |
| Name of referrer | Click here to enter text |
| Referrer direct email | Click here to enter text |
| Referrer telephone number | Click here to enter text |
| Designation of referrer | Click here to select option |
| \*Other designation | Click here to enter text |
| Referrer specialty | Click here to select option |
| \*Other specialty | Click here to enter text |
| Designation of referrer base | Click here to select option |
| \*Other referrer base | Click here to enter text |
| Referring hospital (if applicable) | Click here to select option |
| \*Other referring Hospital | Click here to enter text |
| If out of area, please select reason | Click here to select option |
| \*Other out of area reason | Click here to enter text |

# Patient Details

|  |  |
| --- | --- |
| Name | Click here to enter text |
| Date Of Birth | Click here to enter a date |
| NHS Number | Click here to enter text |
| Patient address | Click here to enter text |
| Patient telephone number | Click here to enter text |
| Interpreting services required? | Click here to select option |
| \*Language required | Click here to enter text |

## Mesh Details

|  |  |
| --- | --- |
| Date mesh inserted | Click here to enter a date |
| Mesh insertion hospital | Click here to enter text |
| Mesh insertion surgeon | Click here to enter text |
| Operation note attached (if available) | Click here to select option |
| Number of mesh/ meshes | Click here to select option |
| Brand of mesh/ meshes | Click here to enter text |

### Type of mesh/ meshes

|  |  |
| --- | --- |
| Unknown | Click here to select option |
| Transobturator (TOT) | Click here to select option |
| Retropubic (TVT) | Click here to select option |
| Mini-sling/single-incision | Click here to select option |
| Anterior vaginal prolapse mesh kit | Click here to select option |
| Posterior vaginal prolapse mesh kit | Click here to select option |
| Sacrocolpopexy | Click here to select option |
| Sacrohysteropexy | Click here to select option |
| Other | Click here to select option |
| Please specify other type of mesh/ meshes | Click here to enter text |

### Mesh complications

|  |  |
| --- | --- |
| Erosion/ Extrusion/ Exposure | Click here to select option |
| Pain | Click here to select option |
| Other | Click here to select option |
| Please specify other mesh complication | Click here to enter text |

### Mesh details continued

|  |  |
| --- | --- |
| Patient Presenting Complaint (Include details of surgical and nonsurgical management already provided at the referral centre) | Click here to enter text |
| Data entered in MHRA database | Click here to select option |
| Data entered in national database | Click here to select option |

## Medical History

|  |  |
| --- | --- |
| Previous input from psychology or psychiatry services? | Click here to select option |
| If yes: Outcome letter attached: | Click here to select option |
| Previous input from pain services? | Click here to select option |
| If yes: Outcome letter attached | Click here to select option |
| GP records attached | Click here to select option |
| Medications | Click here to enter text |
| Allergies | Click here to enter text |
| BMI (most recent) | Click here to enter number. |
| BMI date | Click here to enter a date |
| If BMI over 35, please confirm formal referral to local weight management services | Click here to select option |
| Past surgical history (In particular any previous abdominal surgery including caesarean section) | Click here to enter text |

### Patient Comorbidities

|  |  |
| --- | --- |
| Myocardial infarct | Click here to select option |
| Congestive heart failure | Click here to select option |
| Peripheral vascular disease | Click here to select option |
| Cerebrovascular disease | Click here to select option |
| Dementia | Click here to select option |
| Chronic pulmonary disease | Click here to select option |
| Rheumatic disease | Click here to select option |
| Peptic ulcer disease | Click here to select option |
| Mild liver disease | Click here to select option |
| Diabetes without chronic complication | Click here to select option |
| Diabetes with chronic complication | Click here to select option |
| Hemiplegia or paraplegia | Click here to select option |
| Renal disease | Click here to select option |
| Any malignancy without metastasis | Click here to select option |
| Leukaemia | Click here to select option |
| Lymphoma | Click here to select option |
| Moderate or severe liver disease | Click here to select option |
| Metastatic solid tumour | Click here to select option |
| AIDS | Click here to select option |
| Other | Click here to select option |

# MDT Referral Details

|  |  |
| --- | --- |
| Date of this referral to Bristol MDT | Click here to enter a date |
| Date first referred to Bristol MDT | Click here to enter a date |
| Please indicate purpose of MDT referral | Click here to select option |
| Please specify other purpose of MDT referral | Click here to enter text |
| Discussed at local/regional MDT? | Click here to select option |
| Local/regional MDT outcome form attached? | Click here to select option |
| MDT Clinical Discussion Details (please specify any questions to be answered by MDT) | Click here to enter text |

### Investigations completed you wish to be reviewed at MDT

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Date** | **Details (including how/where we can review the results/images)** | **Patient aware of result** |
| **USS** | Enter date | Click here to enter text | Choose an item |
| **MRI** | Enter date | Click here to enter text | Choose an item |
| **CT** | Enter date | Click here to enter text | Choose an item |
| **Cystoscopy** | Enter date | Click here to enter text | Choose an item |
| **Urodynamics** | Enter date | Click here to enter text | Choose an item |
| **Other** | Enter date | Click here to enter text | Choose an item |

All sections of the form must be completed for MDT discussion to take place, incomplete forms will cause delay in discussion.

Please email completed forms and a copy of the clinic letter to:

[Contact email address](mailto:bristolmeshservice@nbt.nhs.uk) (bristolmeshservice@nbt.nhs.uk)

# TRIAGE OUTCOME (for completion by Bristol Mesh Complications Specialist Service)

|  |  |
| --- | --- |
| Name of triaging person | Choose a name. |
| Date of triage | Click here to enter a date |

## Triaging of Referral

|  |  |
| --- | --- |
| Click to select | Accept and book in One Stop Mesh Clinic (complete tables below) |
| Click to select | Accept and book in mesh clinic with transfer of any results |
| Click to select | Accept and discuss in MDT meeting |
| Click to select | Accept and request investigations prior to clinic |
| Investigations requested: | Click here to enter text |
| Click to select | Accept and book in other clinic (please specify) |
| Other clinic details: | Click here to enter text |
| Click to select | Reject and send back to referrer |
| Rejection reason: | Click here to enter text |
| Click to select | Reject pending further information |
| Click to select | Other (please specify) |
| Other details: | Click here to enter text |

## Mesh One Stop Clinic Details

### Book with Following Specialist/ Specialists

|  |  |
| --- | --- |
| Click to select | Urology Consultant and/or Urology Specialist Nurse |
| Click to select | Gynaecology Consultant and/or UroGynaecology Specialist Nurse |
| Click to select | Orthopaedic Consultant |
| Click to select | Pain Specialist Consultant |
| Click to select | Psychologist |

### Intervention/ interventions required in clinic

|  |  |
| --- | --- |
| Click to select | Flexible cystoscopy |
| Click to select | Flow Test |
| Click to select | Translabial Ultrasound scan |
| Click to select | Urodynamics |
| Click to select | Other |
| Other Intervention: | Click here to enter text |