



PLEASE COMPLETE ALL FIELDS ON PAGES 1 & 2

EMAIL (preferred method) to cmicb-cheshire.echospicetransfusion@nhs.net or
FAX to 01625 665697

Please telephone the Advanced Nurse Practitioners if any queries – 01625 665683

To process referrals without delay please send: **Past medical history**
Medication summary
Recent hospital correspondence

<p>1. <u>Patient details</u></p> <p>Title: Mr / Mrs / Ms / Other _____</p> <p>Surname _____</p> <p>Forename(s) _____</p> <p>Date of Birth _____</p> <p>Ethnicity _____ Religion _____</p> <p>Home address _____</p> <p>_____</p> <p>Postcode _____</p> <p>Tel _____</p> <p>Mobile _____</p> <p>NHS number _____</p> <p>Does the patient live alone: Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Is the patient aware of: Referral <input type="checkbox"/> Diagnosis <input type="checkbox"/> Prognosis <input type="checkbox"/></p> <p>Where is the patient at present: Home <input type="checkbox"/> Other <input type="checkbox"/> If other give details: _____</p> <p><u>Next of kin name</u> _____</p> <p>Relationship to patient _____</p> <p>Next of kin address _____</p> <p>_____</p> <p>Tel _____ Mobile _____</p> <p>Aware of: Referral <input type="checkbox"/> Diagnosis <input type="checkbox"/> Prognosis <input type="checkbox"/></p>	<p>2. <u>G.P. details</u></p> <p>G.P. Name _____</p> <p>Practice Name/address _____</p> <p>_____</p> <p>Postcode _____</p> <p>Telephone _____</p> <p>3. <u>Reason for referral</u></p> <ul style="list-style-type: none">Blood transfusion <input type="checkbox"/> <p>Please note – the patient will not be considered for a day case transfusion if request is for more than 2 units, if they have a cardiac or renal history, functional ability is limited or there is no responsible adult available to stay with them for 24 hours following transfusion. We are unable to accommodate those who cannot provide own private transport – hospital transport is not suitable as we need to adhere to strict arrival and discharge times.</p> <p>4. <u>Consent</u></p> <p>Patient consents to EMIS sharing <input type="checkbox"/></p> <p>5. <u>Hospice Use only</u></p> <p>Referral received _____</p> <p>Patient EMIS number _____</p>
--	--

BLOOD TRANSFUSION REFERRAL FORM
Page 2



**East Cheshire
Hospice**

PLEASE COMPLETE ALL FIELDS ON PAGES 1 & 2

EMAIL (preferred method) to cmicb-cheshire.echospicetransfusion@nhs.net or
FAX to 01625 665697

Please telephone the Advanced Nurse Practitioners if any queries – 01625 665683

Patient Name: _____

Date of Birth _____

6. Clinical Information

Primary diagnosis _____

Date of diagnosis _____ **Where diagnosis made** _____

Method of diagnosis: Biopsy Scan - Type _____ **Other** _____

Site of metastases if present _____ **Date of diagnosis** _____

Treatment details and dates _____

Significant Past Medical History _____

Any known allergies? Yes No **Detail:** _____

Infection risk? Yes No **If yes, please detail:** _____

Transfusion request information _____ **Number of units required** _____

Reason for transfusion / infusion _____

Symptoms? _____

Most recent blood results – Date _____ **(within 5 days of referral)**

Sodium..... **ALP**..... **Hb**.....

Potassium..... **ALT**..... **WCC**.....

Urea..... **Bilirubin**..... **Neutrophils**.....

Creatinine..... **Globulin**..... **Platelets**.....

eGfr..... **GGT**.....

Albumin.....

(please note transfusion may not be considered if hB greater than 80g/litre)

Calcium.....

Adj calcium.....

7. Referring Clinician

Name (print) _____ **Signature** _____

Designation _____ **Contact Number** _____

If referring clinician is not patient's G.P., have you discussed/agreed the referral with G.P.?

Yes **No** **if no, give reason** _____ **Date of discussion** _____