BLOOD TRANSFUSION REFERRAL FORM
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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
To process referrals without delay please send: Past medical history
Medication summary
Recent hospital correspondence

1. Patient details

Title: Mr / Mrs / Ms / Other_____

Surname_____

Forename(s)_____

Date of Birth_____

Ethnicity_____Religion_____

Home address_____

_____

Postcode_____

Tel_____

Mobile_____

NHS number_____

Does the patient live alone: Yes ☐ No ☐

Is the patient aware of:
Referral ☐ Diagnosis ☐ Prognosis ☐

Where is the patient at present: Home☐ Other☐
If other give details:_____

Next of kin name_____

Relationship to patient_____

Next of kin address_____

_____

Tel_____Mobile_____

Aware of: Referral ☐ Diagnosis ☐ Prognosis ☐

2. G.P. details

G.P. Name_____

Practice Name/address_____

_____

Postcode_____

Telephone_____

3. Reason for referral

- Blood transfusion ☐

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.

4. Consent

Patient consents to EMIS sharing ☐

5. *Hospice Use only*

Referral received_____

Patient EMIS number_____

East Cheshire Hospice
Millbank Drive
Macclesfield
Cheshire SK10 3DR

Tel: 01625 610364 (Reception)
01625 433477 (Fundraising)
Fax: 01625 612611
Email: admin@echospice.org.uk

Registered Charity Number: 515104
Limited by Guarantee Number: 1807691

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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
Calcium.....		if hB greater than 80g/litre)
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_____