|  |  |  |  |
| --- | --- | --- | --- |
| **Patient Name:**   | Click here to enter text. | **Referral Date:**  | Click here to enter a date. |
| **CHI:**  | Click here to enter text. | **Consultant:**  | Click here to enter text. |
| **Health Board:** | GGC | **Referring Clinician:** | Click here to enter text. |
| **DoB:**  | Click here to enter text. | **Contact e-mail:**@ggc.scot.nhs.uk |
| **Age:**  |  |  |
| **Indication for Referral:** |
| Mesh complication |
| **Mesh Perforation**  | [ ]  | **Mesh Exposure**  | [ ]  | **Chronic Pain**  | [ ]  | **Sepsis**  | [ ]  |
| **Other** (please describe): | [ ]  | Click here to enter text. |
| **Details of Patient Symptoms:**  |
| Click here to enter text. |
| **Detailed Implant History with Operation Note:** |
| Click here to enter text. |
| **Mesh Type -** | Click here to enter text. |
| **Manufacturer -** | Click here to enter text. |
| **Date of Implantation -** | Click here to enter text. |
| **Incident Reporting & Investigation Centre (IRIC) Ref Number:** |
| Click here to enter text. |
| **Past Surgical History** (in particular any previous abdominal surgery inc caesarean section): |
| Click here to enter text. |
| **BMI:** | Click here to enter text. |
| **Comorbidities:** |
| Heart disease (e.g. angina, previous MI, valvular disease/AF) - | Click here to enter text. |
| Diabetes (please specify medication) - | Click here to enter text. |
| Respiratory Disease (COPD/asthma/PEs etc) - | Click here to enter text. |
| Anticoagulation Therapy- | Click here to enter text. |
| Other Significant Comorbidities - | Click here to enter text. |
| Performance Status (WHO 0-4) - | Click here to enter text. |
| **Examination Findings:** |
| Click here to enter text. |
| **Investigations** (Please provide-findings / results / dates / operation notes): |
| **Cystoscopy** Click here to enter text. |
| **Urodynamics**Click here to enter text. |
| **Lower GI Endoscopy**Click here to enter text. |
| **Imaging (MR, CT, US)** Click here to enter text. |
| **Other** Click here to enter text. |
| **Non-surgical treatment** (Please provide details- what / when / where): |
| Click here to enter text. |
| **Pain Team**  | Choose an item. | **Outcome:** Click here to enter text. |
| **Physio** | Choose an item. | **Outcome:** Click here to enter text. |
| **Psychology** | Choose an item. | **Outcome:** Click here to enter text. |
| **Patient’s expectations from referral:** |
| Click here to enter text. |
| **MDT Triage:** | **Date:**  Click here to enter a date. |
| Click here to enter text. |
| **Back to Local Unit with Advice** |[ ]  **See at Multidisciplinary Clinic** |[ ]  **Admit for Investigations** |[ ]
| **MDT Plan:** | **Date:** Click here to enter a date. |
| Click here to enter text. |
| **Additional MDT Review:** | **Date:** Click here to enter a date. |
| Click here to enter text. |
| **Waiting List if Surgery Planned:** |
| **Joint Case:** | **Sub Specialist** |[ ]  **Colorectal** |[ ]  **Urology** |[ ]
| **IP - 2** |[ ]  **IP - 3** |[ ]  **IP - 4** |[ ]
| **Action Plan:**  | **MDT Date:** Click here to enter a date. |
| Click here to enter text. |

**;.**