

**This form should be submitted via the Referral Support Service**

## Reference/Priority

Referral Date: <input type="text" value="Referral Date"/>	Priority: <input type="text" value="Referral Urgency"/>	NHS Number: <input type="text" value="NHS Number"/>
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## Patient Details

Title: <input type="text" value="Title"/>	Forename(s): <input type="text" value="Given Name"/>	Surname: <input type="text" value="Surname"/>
Date of Birth: <input type="text" value="Date of Birth"/>	Gender: <input type="text" value="Gender"/>	Ethnicity: <input type="text" value="Ethnic Origin"/>

## Contact Details

Address Line 1: <input type="text" value="Home Address House Name/Flat Number"/>	Address Line 2: <input type="text" value="Home Address Number and Street"/>	Address Line 3: <input type="text" value="Home Address Village"/>
Town: <input type="text" value="Home Address Town"/>	County: <input type="text" value="Home Address County"/>	Postcode: <input type="text" value="Home Address Postcode"/>
Phone: <input type="text" value="Patient Home Telephone"/>	Mobile: <input type="text" value="Patient Mobile Telephone"/>	Text Message Consent: <input type="text" value="No"/>
Email: <input type="text" value="Patient E-mail Address"/>		

## Referrer/Practice Details

Referring Name: <input type="text" value="Referring User"/>	Referrer Code: <input type="text" value="Free Text Prompt"/>	Practice Code: <input type="text" value="Organisation National Practice Code"/>
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## Clinic Details

Specialty: <input type="text" value="Free Text Prompt"/>	Clinic Type: <input type="text" value="Free Text Prompt"/>	Named Clinician: <input type="text"/>
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## Patient Choice Preferences

Provider 1: <input type="text" value="Referral Target Service Name"/>	Provider 2: <input type="text"/>
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## Preferences

Vulnerable Patient: <input type="text" value="No"/>	Vulnerable Reason: <input type="text"/>	Confidential/Silent Referral: <input type="text" value="No"/>
Preferred Contact Time: <input type="text"/>	Interpreter Required: <input type="text" value="No"/>	Preferred Language: <input type="text" value="Main Language"/>

## Referral Details

Non-clinical information for the booking team:

Provisional Diagnosis:

Smoking Status:

## Referral Reason/Letter Text

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## Referral Criteria -This policy only applies to patients age 18 and over

Is this referral for a surgical specialty? Please answer Yes or No Unknown  
 If Yes, please tick the applicable option(s) below or tick exclusion reason  
 If No, the remainder of this section does not require completion

**Option 1 - Non-smoker with BMI <30 (the rest of this form does not require completion)**

**Option 2 - Current Smoker or BMI of 30 or above but referral is to a surgical specialty for a medical condition only (the rest of this form does not require completion)**

**Option 3 - Active smoker or BMI of 30 or above but referral is for a surgical opinion only**

**Option 4 - Active smoker or BMI of 30 or above requiring surgery**

### For options 3 & 4

Please complete BMI and smoking status in the table below:

Date of 'Time 0': \*Time 0 = date when initial smoking status and BMI taken and lifestyle advice given

Smoking status:

Weight:

BMI:

## Exclusions Criteria

**If any of the following exclusions apply to this referral BMI and Smoking Status are not required. Please select exclusion reason.**

Patients requiring emergency surgery or with a clinically urgent need where delay would cause clinical risk

Referral for interventions of a diagnostic nature e.g. gastroscopy, colonoscopy, laparoscopy, hysteroscopy, cystoscopy, nasopharyngolaryngoscopy

Patients with advanced or severe neurological symptoms of Carpal Tunnel Syndrome i.e. constant pins and needles, numbness, muscle wasting and prominent pain and that are significantly affecting activities of daily living

Patients who despite having a BMI >30 have a waist circumference of:

- Less than 94cm (37 inches) male
- Less than 80cm (31.5 inches) female

Patients receiving surgery for the treatment of cancer or the suspicion of cancer

Any surgical interventions that may be required as a result of pregnancy

Patients requiring Cataract Surgery

Patients with severe mental illness, learning disability or significant cognitive impairment **(NB: Refer to Appendix A on the RSS website for more detail)**

Surgery approved by IFR Panel (attach IFR Approval)

12 month health optimisation period complete (BMI status)

6 month health optimisation period complete (smoking status)

## Patient Readcoded Values

EHIC: Single Code Entry: European health insurance card (EHIC) held

Smoking Status: Single Code Entry: Smoking Status

Religion: Single Code Entry: Religion

## Active Problems

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Family History

Problems

Values and Investigations

Allergies

Alcohol Consumption

Smoking

Weight

Height

Blood Pressure

BMI

## Medication

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Medication

## Lab Results

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Radiology

HbA1c

Urinalysis

Haematology

Lipids

## Diagnostics

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ECG

Peak Flow

Cervical Smear