**GROMMETS IN ADULTS REFERRAL FORM**

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| **\*To:** | **Referral Date:** **<Today's date>** |
| **\*Specialty:** | **\*Sub Specialty** (*if appropriate)*: |
| **\*Provider Booking Department** (*Insert provider organisation*): | |

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| **Patient Details** | | **GP Details** | |
| **Forename:** | <Patient Name> | **Referring GP:** | <GP Name> |
| **Surname:** | <Patient Name> | **Registered GP:** | <GP Name> |
| **Date of Birth:** | <Date of birth> | **Practice:** | <Organisation Details>  <Organisation Address> |
| **NHS No:** | <NHS number> |
| **Gender:** | <Gender> |
| **Ethnicity:** | <Ethnicity> |
| **Hosp No** (if known)**:** |  |
| **Address:** | <Patient Address> |
| **Telephone:** | <Organisation Details> |
| **Fax:** | <Organisation Details> |
| **Practice code:** | <Organisation Details> |
| **Home Tel No:** <Patient Contact Details>  **Work Tel No:** <Patient Contact Details>  **Mobile Tel No:** <Patient Contact Details> | | | |

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| **CLINICAL THRESHOLD - Grommets in Adults** |
| **Instructions for use:**  Please refer to policy for full details, complete the checklist and file for future compliance audit.  The CCG will only fund Grommets for Adults when the following criteria are met:   |  |  | | --- | --- | | *In ordinary circumstances\*, referral should not be considered unless the patient meets* ***one or more*** *of the following criteria:* | Tick as appropriate | | Persistent hearing loss for at least three months with hearing levels of 25dB or worse on pure tone audiometry **OR** | Yes  No | | Recurrent acute otitis media - 5 or more episodes in the preceding 12 month period **OR** | Yes  No | | Eustachian tube dysfunction causing pain **OR** | Yes  No | | Atelectasis of the tympanic membrane where development of cholesteatoma or erosion of the ossicles is a risk. **OR** | Yes  No | | As a conduit for drug delivery direct to the middle ear **OR** | Yes  No | | In the case of conditions e.g. nasopharyngeal carcinoma, ethmoidal cancer, maxillectomy, olfactory neuroblastoma, sinonasal cancer, and complications relating to its treatment (including radiotherapy), if judged that the risks outweigh the benefit by the responsible clinician **OR** | Yes  No | | Part of a more extensive procedure at consultant’s discretion, such as tympanoplasty, acute otitis media with facial palsy | Yes  No |   *\* If clinician considers need for referral/treatment on clinical grounds outside of these criteria, please refer to the Individual funding request policy for further information.* |

**PLEASE NOTE:** Secondary Care to reject referral if this form is not complete and return patient to Primary Care.

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| **GET FIT FIRST IN BARNSLEY**  Please complete **one** of either:   * Form A part 1 (Referral for Assessment / Diagnosis / Review) * Form A part 2 (GFF not applicable)   Form B (GFF completed) |
| **FORM A - PART 1 – Referral for Assessment / Diagnosis / Review**  **Please note:** For referrals for opinion/review/diagnostic sent to secondary care – please advise the patient that the Get Fit First health improvement policy may be required if surgery is indicated.  Patients may be referred back to Primary Care to initiate the Get Fit First Policy prior to surgery.  **\*Reason for Referral:**   * **Assessment**  **Yes**  **No** * **Diagnosis  Yes  No** * **Review  Yes  No** |
| **FORM A - PART 2 - Get Fit First – not applicable**  **Patients BMI is under 30 / patient is a non-smoker:**  **Yes**  **No**  **Please list any other clinical reason/s for exemption here:**  **IFR approval attached:**  **Yes**  **No**  **BMI:**<Latest BMI>  **Height:** <Latest Height>  **Weight:** <Latest Weight>  **Smoking:** <Diagnoses>  **Waist measurement:** <Numerics> |

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| **FORM B - Get Fit First Policy Completed**  **If the patient declined to attend either smoking cessation or weight management, please ensure that the 6 month health improvement period has been completed and provide evidence of this below:**  **BMI:** <Latest BMI>  **Height:** <Latest Height>  **Weight:** <Latest Weight>  **Smoking:** <Diagnoses>  **Waist measurement:** <Numerics>  **For patients that have followed the Get Fit First Policy AND their metrics remain outside the Get Fit First Policy:**   * **Please confirm start and end date of health improvement:**    + **Start**   + **End**   + **Duration**   **Any other clinically relevant comments:** |

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| Dear Colleague,  Thank you for kindly seeing this patient.  **Presenting Complaint**    **Relevant Clinical Findings**    **Action to be Taken**    I have attached my recent consultation herewith which is also self-explanatory. I will appreciate your assessment and advice.  Many thanks.  <GP Name> |

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| **\*Interpreter required?** Yes/ No**.**  **If yes, please state which language:** |

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| **MEDICAL HISTORY**   * **History**   Active Problems  <Problems(table)>  Significant Past  <Problems(table)>   * **Last Consultation/s**   <Event Details(table)>   * **Current medication:**   Acute  <Medication(table)>  Repeat  <Medication(table)>   * **Blood Pressure:**   <Last 5 BP Reading(s)(table)>   * **Alcohol Consumption**   <Numerics>   * **Current allergies**   <Allergies & Sensitivities(table)> |

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| **LABORATORY RESULTS (Latest result within last year unless stated)** Lipids   **Glucose / HbA1c** Liver Function TestsRenal / Prostate FunctionHaematologyThyroid FunctionUrinalysisPeak Flow **Histology / ECG / Radiology (Last 2 years)** |