**` Referral form for PHOTOPHERESIS (ECP)**

**ECP UNIT Tel. No. 0207 1886308**

*Please speak to the ECP Nurse in charge**& fax this completed referral form to* ***88145***

Patient Name …………………

Hospital Number …………….

Date of birth:………………… .

**Date/ Time: ……………………………...** **Consultant:**

**Referrer name: …………………………**

**Referrer Signature: ……………………**

**Diagnosis: ……………………….……….**

Tel no/s.……………………………………….

………………………………………………..

**Planned admission / treatment start date: …………………………………………………….**

**Reason for patient admission (tick one or more boxes):**

**Photopheresis two weekly or once a month**

**IV Therapy** IV drug/s required::…………………………………………………

(Treatment will be administered as per each individual drug protocol)

**Is hospital accommodation required?** Yes No

*Assess suitability for Simon Hotel (SH) and (CH) using the criteria*

**Requires: SH or CH**

**Has MRSA screen been completed? Yes No Date………….………..**

**Result :………………………………… +VE -VE**

|  |
| --- |
| **Please provide details of any investigations required prior to OR during admission:** |

## Referrals to be made on admission:

|  |  |  |  |
| --- | --- | --- | --- |
| **Pain team** |  | **Palliative care** |  |
| **Foot Health** |  | **Social services** |  |
| **Dietician** |  | **EB counsellor** |  |
| **Other** | | | |
| **Other** | | | |

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| --- |
| **Official use only**  **Received and reviewed by: …………….……………… Date /Time…………………………………..**  **Outcome**  **1: admission approved for date required**  **2. Delayed until…...................................** |