***Referral form – SHAPMS***

Stoma referrals to the Surrey Heartlands Appliance Prescription Management Service are only for patients with a stoma and/or fistula who are registered with a GP practice within the Surrey Heartlands Integrated Care Board (ICB).

All \*fields must be completed by the referrer and emailed to **prescriptionservice.bhg@nhs.net**Information is confidential and privileged. If you receive this in error, please inform us and destroy this.

Completed referrals need to be emailed to**prescriptionservice.bhg@nhs.net**which is monitored Monday – Friday 9am – 5pm (excluding bank holidays). Referrals are actioned within 2 working days of receipt.

**This referral is to register a patient with a new stoma formation **

**This referral is to advise of patients products post review **

**Patient Details**

|  |
| --- |
| Name: |
| DOB: | NHS No: |
| Address: |
| Home Number: | Mobile Number: |
| Email: |  |
| Patients chosen dispenser: |  |

**GP Details**

|  |  |
| --- | --- |
| GP Name: |  |
| Surgery Name: |  |
| Telephone Number: |  |

**Clinical Details**

|  |  |
| --- | --- |
| Type of stoma: |  |
| Date of stoma formation & Operation: |  |
| History: Cancer, Crohns, UC, Other |  |
| Relevant Medication: e.g. loperamide, metformin  |  |

**Additional Referral Details or Comments**

|  |
| --- |
|  |

**Product Details**

|  |  |  |  |
| --- | --- | --- | --- |
| ***Manufacturer*** | ***Product Name*** | ***Product Code*** | ***Quantity*** |
|  |  |  |  |
|  |  |  |  |
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**Referrer Details**

|  |  |
| --- | --- |
| Name of referrer: |  |
| Organisation:  |  |
| Telephone: |  |
| Email address: |  |
| Date of referral: |  |
| Signature of referrer: |  |